February, 1959 Volume XX, No. 2

REHABILITATION LITERATURE

National Society for
Crippled Children and Adults

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

As a reviewing and abstracting journal, *Rehabilitation Literature* identifies and describes current books, pamphlets, and periodical articles pertaining to the care, welfare, education, and employment of handicapped children and adults. The selection of publications listed and their contents as reported is for record and reference only and does not constitute an endorsement or advocacy of use by the National Society for Crippled Children and Adults.

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Books for review and correspondence relating to feature articles and other editorial matters should be addressed to the editor. He will welcome your suggestions.

REHABILITATION LITERATURE

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Earl C. Graham, Editor
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Dr. Rusk Comments

Rehabilitation Medicine

Prevocational Treatment

THERE IS ALWAYS a prevocational treatment element present [in the total treatment program], even when the primary treatment is functional or supportive, but prevocational treatment achieves its full significance only when utilized as a component of vocational counseling services. If prevocational treatment is to be of maximum value to the patient, it must be carried out with equipment of a more industrial or commercial nature and the therapist must have industrial or commercial skills.

"In very broad terms the equipment and skills which the occupational therapist should command will vary with the age grouping.

Occupational Therapy Activity
Distributed by Age

AGE (YR.)	ACTIVITY	EQUIPMENT
1-15	Play	Toys
	Educational	Educational materials
15-60	Hobby	Arts and crafts
	Industrial	Industrial
60 plus	Hobby	Arts and crafts

"With the emphasis of rehabilitation services being extended over the past few years to include prevocational evaluation, the demands for the occupational therapy service to include a prevocational unit to evaluate and report on the potentials of the patient from the point of view of salable skills have become one of the major duties of the service. This has necessitated the setting of new sights in obtaining equipment for the service and the interdependence of the vocational counseling and occupational therapy."

Psychiatric Problems

PERSONALITY CAN BE DEFINED as the sum total of a person's ideas, emotions, and behavior, rational and irrational, conscious and unconscious, defensive and learned. This personality has developed as a result of genetic and environmental factors representing life experiences. Physical disability constitutes a threat to a way of life and tends to disrupt the equilibrium which this way of life represents. It may cause intense anxiety, depression, and rage. It may be interpreted as punishment for sins real or imaged. It may represent a threat to omnipotent strivings or to normal mastery and may produce feelings of helplessness and panic. It may unloose previously controlled psychopathology such as paranoid ideas and create intolerable interpersonal relationships. On the other hand, the disability may be organized into neurotic strivings, such as dependency and fear of competition, and be unconsciously welcome as a way out of a conflictive struggle.

"Finally, the disability removes the individual from normal social experiences and from work situations—the two major sources of satisfaction and self-esteem. Disruption in family life and friendships, separation from loved ones, economic problems, shattered ambitions and dreams—all of these lead to serious threat and damage to the socially functioning human being.

"The disability, then, represents a massive assault on all three of the major areas of functioning. How the individual reacts will depend on a vector resulting from the nature of the disability, the realistic problems it creates, the personality of the individual, his previous history and life experiences, the meaning of the disability both conscious and unconscious, and the resources provided by the individual, his family, and society. It is toward an understanding of these factors and their manifestations that psychiatric evaluation in rehabilitation sets its goal."—*From* Rehabilitation Medicine, *by Howard A. Rusk, M.D. 1958. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. $12.00.*

REHABILITATION LITERATURE

Review of the Month

Developmental Potential of Preschool Children

An Evaluation of Intellectual, Sensory and Emotional Functioning

By Else Haeussermann

Published by Grune and Stratton, Inc., 381 Fourth Ave., New York 16, New York. 1958. 285 p. illus. $8.75.

Reviewed by Raymond H. Holden, M.A.

This new book, with the subtitle "An Evaluation of Intellectual, Sensory and Emotional Functioning," will be gratefully received by those individuals charged with clinical training of psychologists who are endeavoring to understand better and evaluate the functioning of physically handicapped children. It is filled with a wealth of valuable clinical observation, a product of Miss Haeussermann's many years of experience with many kinds of children. However, the educational evaluation described in this book will probably be more acceptable to European trained "educational psychologists" than American trained clinical psychologists, for the reasons given below.

The book opens with a chapter defining the need for an educational evaluation of physically handicapped children. During a quarter century of daily work with children handicapped with cerebral palsy, Miss Haeussermann sought to develop means of inventorying the functional level of each child to determine the effectiveness of training and teaching methods. The procedure of the structured interview developed gradually over a period of 15 years of pragmatic use. The object of the educational evaluation is to determine whether a child can, by whatever motivation is necessary, perform certain sensory, motor, and intellectual functions. Interpretation of the child's performance can then be synthesized into a qualitative statement of his ability including level of communication, sensory intactness, physical condition, self-help ability, vision, hearing, and speech. It is said not to be a standardized test, but supplementary

About the Author . . .

Miss Haeussermann is educational consultant, Division of Pediatric Psychiatry, Jewish Hospital, Brooklyn, New York. Educated in Germany in kindergarten and primary teaching and in social work, she has since 1928 worked continuously with the cerebral palsied. In 1944 she opened her own preschool for cerebral palsied children in Albany and in 1946 she joined the preschool project conducted by the New York Service for Orthopedically Handicapped. This book based upon her study of evaluation methods was made possible through a three year grant from the United Cerebral Palsy Association of New York City.

About the Reviewer . . .

Mr. Holden graduated in 1947, magna cum laude, from Brown University and two years later received his Master's degree in clinical psychology from Yale University. He is clinical psychologist for Crippled Children and Adults of Rhode Island and for the Institute for Research in Health Sciences of Brown University. Some 16 articles on cerebral palsy and psychology written by him have appeared in such journals as Exceptional Children, Child Development, Cerebral Palsy Review, Journal of Pediatrics, Journal of the American Medical Association, and American Journal of Mental Deficiency.

to current tests. Nevertheless, determination of a child's functioning ability is clearly involved.

The book is essentially a test manual in that it provides instructions on how to conduct Miss Haeussermann's Educational Evaluation. This evaluation consists of 40 items presented to the child in a generally increasing order of difficulty. For example, item two is entitled, "Recognition of Concrete Familiar Life-size Objects, when described in terms of use," to be presented from ages 2 to 6, and expected to be passed at Year 2-6 to 3-0. These objects are shoe, spoon, comb and brush, and cup, and the examiner asks questions such as, "Which one do we eat with?" "Which one goes on your foot?" However, it is not stated how many of these four parts should be answered correctly to consider the child has attained success with this item. Nor do we have any mention of what procedure was used to determine that these items are ordinarily passed at ages 2½ to 3. And is this a norm based on nonhandicapped or physically handicapped children or both? Of course, very similar expectations are made of the child at Year 2½ on the Revised Stanford-Binet, but this is nowhere mentioned in the text.

It is perfectly clear that there are many kinds of unstandardized children who cannot be evaluated effectively in a standardized test situation. This is one of the reasons given for developing this new evaluation procedure. There are definite requirements needed of the interviewer, including infinite patience and the ingenuity to adapt himself and modify procedures in the evaluation of perhaps a difficult child. Certainly there is a need for flexibility in approaching the problem of how to get the most out of the child who has either sensory or motor difficulties or who, because of severe emotional disturbance, is not very much in contact with the examiner. It is in these chapters that Miss Haeussermann is at her best.

Some of the advantages of this evaluation procedure are: (1) It transfers the burden of proof from the child to the items and the examiner who evaluates him. This is an excellent goal, but there is no evidence presented that this is true for the evaluation procedure. (2) The child's *comprehension* of what is expected is of the foremost consideration. However, experienced clinical psychologists have stressed this point for a long time. (3) The examiner must become more flexible and more closely observant of slight cues in behavior. No one would argue with this, but experience tends to develop these qualities in an examiner, regardless of the evaluation situation used.

Certain obvious disadvantages are noted: (1) The evaluation, which proceeds through a total of 40 numbered items, is said to take from a minimum of 45 minutes to 2 hours or more. This definitely would be fatiguing for any young child, although it is noted that two sessions may be utilized. (2) Academic training is said not to prepare the examiner for the present evaluation role. This would be a blow to the clinician, who would not be able to learn this technic in graduate school and who would need extremely specialized preparation. But from whom? (3) A minor point, but there is an inconsistent numbering of items; 40 items are numbered but there are actually 46 items in the evaluation procedure.

It will be noted that the foregoing discussion omits the word testing, mainly because the evaluation procedure

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"The assessment of the intelligence of a child with cerebral palsy involves much more than the administration of an intelligence test. It entails a full and detailed study of the child, his physical, sensory and speech handicaps, and the effect of these on his experiential background. His own and his parents' attitude towards his disability play a large part in determining how much independence he develops and hence influences his ability and his desire to overcome difficulties and to solve problems."—"Intelligence Testing," by F. Eleanor Schonell, in *Recent Advances in Cerebral Palsy,* edited by R. S. Illingworth. Little, Brown and Company, 34 Beacon St., Boston, Mass. 1958. $12.00.

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attempts to provide for a testing of the child but unfortunately without any of the currently expected procedures for scientific evaluation of a test procedure. The disturbing thing about this book is that Miss Haeussermann has attempted to come to grips with certain methodological problems but has ended with justifications for not using scientifically tested procedure for establishing her evaluation as a good predictor of actual success in a rehabilitation or educational program. Dr. Birch in his introduction has fallen into the trap of describing the evaluation as a "new test" but Miss Haeussermann (p. 57) states "it is not a standardized test" and that it "resembled testing but also differs from testing" (p. 63). Yet there is no evaluation of the relationship between the results of this procedure and other commonly used testing instruments, such as the Revised Stanford-Binet, the Merrill-Palmer Scale, or the Columbia Mental Maturity Scale. The burden of proof rests on Miss Haeussermann to demonstrate that her procedure predicts a young child's adjustment and progress better than any commonly used test. This she does not do in any way, neither by correlation with testing instruments nor with success in nursery school or other educational placement. There is no mention of how many children have been seen or what the results of these evaluations have been. It is not stated anywhere how many cerebral palsied, autistic, mentally deficient, or abnormal children have been evaluated. Thus, a description of the population already evaluated (by age, sex, IQ, medical diagnosis, socioeconomic status, degree of physical handicap, if any) is not given. Problems of reliability and validity are nowhere discussed. The materials for the evaluation, which mainly include common everyday objects and toys familiar to children, are nonstandardized in that they are not available in a kit at the present time, and the evaluation procedure itself is said to be in a continuing

state of revision (p. 46). There is an extensive 80-item bibliography to which no reference is made in the text.

This book contains excellent discussions of how to modify testing procedures to get the most from a hyperactive, aggressive, retarded, withdrawn, or overprotected child. There is throughout a warmth and a fine sensitivity and awareness of children's needs. One could not disagree with Dr. Birch's statement in the introduction that this probably is "the best available textbook for the clinical evaluation of behavioral functions in the brain-damaged or retarded child." However, one is definitely more impressed with Miss Haeussermann's clinical acumen than with the scientific rigor that has accompanied the development of this new evaluation procedure.

Review of the Month for March

The March issue of *Rehabilitation Literature* will give special attention to the new book *Recent Advances in Cerebral Palsy,* edited by R. S. Illingworth, M.D. Our reviewer is Eric Denhoff, M.D., pediatric specialist in cerebral palsy and Chairman, Research Committee, American Academy for Cerebral Palsy, 1950-1955.

Other Books Reviewed

71

Cerebral Vascular Diseases; Transactions of the Second Conference held under the Auspices of the American Heart Association, Princeton, N.J., January 16-18, 1957

Edited by: **Clark H. Millikan**

1958. 224 p. tabs. Grune & Stratton, 381 Fourth Ave., New York 16, N.Y. $4.00.

Twelve main topics covered by Conference participants included: cerebral blood flow, problems of nomenclature, rehabilitation problems, relationship of hypertension to cerebral vascular disease, intermittent cerebral ischemia, surgical aspects of hemorrhage, experimental studies with enzymes in the treatment of thrombosis, anticoagulant therapy, evaluation of current approaches to the therapy of atherosclerotic disease, and comparison of blood vessels. Current research was evaluated and new developments in this area discussed. Clinical case material was cited and specific areas for further study suggested. A special section "The Classification and Outline of Cerebrovascular Diseases," prepared by a committee established by the Advisory Council for the National Institute of Neurological Diseases and Blindness, is a valuable addition to the book. (The classification originally appeared in *Neurology,* May, 1958. 8:5:395-434)

72

Directory of Catholic Facilities for Exceptional Children in the United States

By: **National Catholic Educational Association**

1958. 248 p. 3d ed. National Catholic Educational Association, 1785 Massachusetts Ave., N.W., Washington 6, D.C. $2.75.

A revised and greatly expanded directory of all residential and day class facilities and clinics offering medical and adjunctive therapy services for exceptional children now in operation under the Catholic school system in the United States. Schools and agencies serving the physically, mentally, and emotionally handicapped are listed; some services available for adults are also given. The directory is unusually comprehensive and should be most useful for all those working with or preparing to work with the exceptional child since it includes additional references to agencies in the rehabilitation field that are not under Catholic auspices.

73

Early Education of the Mentally Retarded; An Experimental Study

By: **Samuel A. Kirk** (and others)

1958. 216 p. tabs. University of Illinois Press, Urbana, Ill. $6.00.

Extensive case analysis of mentally retarded children between the ages of 3 and 6 was used to illustrate forcefully the effects of preschool education on their mental and social development. Important legal and social implications of this report of a five-year experiment point up the responsibility of the community in providing services that would compensate for deficiencies in their home environment. The evidence presented suggests that, within limits, deprived environments in the home or in the wards of an institution can serve as a cause of mental retardation in some children. Dr. Kirk reviews the literature dealing with the influence of heredity and environment on the personality and mental development of mentally retarded persons; controversial viewpoints are summarized. Findings of the experiment indicated that 70% of the 43 children who received preschool education showed an acceleration in rate of growth during the preschool period and maintained that level during the follow-up period. Although it was found to be more difficult to improve rate of growth in children with organic deficiencies, half of these children made some improvement.

The author is Director of the Institute for Research on Exceptional Children, University of Illinois, Urbana, and a former president of the Council on Exceptional Children.

74

Frontiers of Elementary Education, V; Papers Presented at the Fifth Annual Conference on Elementary Education . . . Syracuse University, 1958; comp. and ed. by Vincent J. Glennon

By: **Syracuse University School of Education**

1958. 102 p. Syracuse University Press, University Station, Box 87, Syracuse 10, N.Y. $1.75.

Following the pattern of proceedings of previous years' conferences, this book offers thoughtful and scholarly discussions of a number of problems in regard to elementary education and the school child. Areas of interest covered ranged from graduate programs in professional education, the teaching of reading and arithmetic, supervision of instruction, and the education of exceptional children, through mental hygiene, the development of effective listening skills, and curriculum planning for continuity in learning. Since the content of the annual J. Richard Street Lecture was pertinent to the elementary school teacher, Dr. Gardner's paper on "Tomorrow's graduate school of education" has been included. Dr. Maurice H. Fouracre (p. 34-42) and Dr. Oliver P. Kolstoe (p. 71-77) contributed chapters on exceptional children.

75

Gateways to Readable Books; An Annotated Graded List of Books in Many Fields for Adolescents Who Find Reading Difficult

By: **Ruth Strang, Ethlyne Phelps,** and **Dorothy Withrow**

1958. 181 p. 3d ed. H. W. Wilson Co., 950 University Ave., New York 52, N.Y. $3.00.

First published in 1944, brought up to date in a second edition issued in 1952, and currently offered in a third revision, this bibliography includes more than 1,000 titles of easy-to-read books covering many fields of interest to adolescent students. Eighty per cent of the entries are new additions; the majority of books listed are of fifth, sixth, and seventh grade level of reading difficulty. Briefly annotated entries are simple in style so that pupils may use the bibliography in choosing books that might interest them; each is classified according to subject, with reading level indicated. Additional aids for the teacher are the author, title, and reading difficulty indexes, a directory of publishers, and a list of magazines and newspapers of interest to high school students.

76

Hope for the Stricken; The Story of a Quadriplegic

By: **Alfred H. Thiese**

1958. 221 p. Vantage Press, 120 W. 31st St., New York 1, N.Y. $3.50.

The personal account of an Iowa farmer's experiences after a fall from the top of a truckload of hay bales caused him to become paralyzed from the neck down. He tells of the ordeal of hospitalization and his eventual return home, his courageous attempts to overcome the many problems that the quadriplegic faces daily, and the strength that he drew from the kindness and help given by his family and friends. With the aid of a specially constructed wheelchair, he is now able to move about the house and yard.

77

I'm Handicapped for Life; The Story of an 18-Year-Old's Fight Against Cerebral Palsy

By: **Gerald D. Smoot**

1958. 54 p. Vantage Press, 120 W. 31st St., New York 1, N.Y. $2.50.

Written by a cerebral palsied boy in his senior year of high school, this book is interesting in that it reveals the reactions of a handicapped teenager to his world and to the persons with whom he has come in contact. Unable to walk or talk coherently until the age of five, Gerald has overcome his many handicaps to the extent that he attended regular classes during most of high school, achieved a "B" average in his studies, had many friends among his fellow students, and participated in the social and athletic events of the school. Presently a student at Eastern Michigan College, he is determined to lead a "normal" life if those around him will accept his normality. He describes attitudes of nonhandicapped persons that help or hinder the progress of the handicapped toward an accepted place in society.

78

Mental Subnormality; Biological, Psychological, and Cultural Factors; A Survey of Research Sponsored by the National Association for Retarded Children

By: **Richard L. Masland, Seymour Sarason,** and **Thomas Gladwin**

1958. 442 p. figs., tabs. Basic Books, Inc., 59 Fourth Ave., New York 3, N.Y. $6.75.

Based on three years of intensive research sponsored by the National Association for Retarded Children, this important contribution to the literature reports in detail the authors' findings on the possible causes of mental deficiency. The complex interaction of neurological, chemical,

psychological, hereditary, cultural, and environmental factors operating before, during, and after the actual birth process was studied. Two reports, originally published separately but actually two facets of the same problem, are included. (For the earlier publications, see *Rehab. Lit.*, Apr., 1958, #390 and Aug., 1958, #948.) Separate reviews of the research on biological factors and psychological and cultural factors present a comprehensive and authoritative summary of current knowledge in regard to the problem. The survey should point the way to further areas of research needed and to the more effective planning of programs of prevention, management, and education of mentally deficient children. A bibliography of over 600 references is included.

79

The Nation's Health Facilities; Ten Years of the Hill-Burton Hospital and Medical Facilities Program, 1946-1956

By: **U.S. Public Health Service** (Prepared by Leslie Morgan Abbe and Anna Mae Baney)

1958. 181 p. charts, tabs. (*Public Health Serv. publ. no. 616*) Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at $1.25 a copy.

A review of the status of all types of health facilities, currently existing or planned under the Hill-Burton program, as of July, 1956. A comprehensive analysis of the 1956 State Plans was made and background data supplied. Limited data for January, 1958, is contained in an appendix. The review of rehabilitation facilities (p. 95-99) will be of special interest since it describes how the Hill-Burton Act was expanded to include provisions for the construction of facilities offering rehabilitation services. Also defined are the terms rehabilitation facility, integrated program, and disabled person, as set forth in the regulations. Data are given on existing facilities and their use, disability groups served, and standards of need.

80

Nurse-Patient Relationship in Psychiatry

By: **Helena Willis Render** and **M. Olga Weiss**

1959. 319 p. 2d ed. The Blakiston Division, McGraw-Hill Book Co., 330 W. 42nd St., New York 36, N.Y. $5.95.

A revised edition of a text specifically designed for the student nurse who will be working for the first time with the mentally ill in psychiatric units. Useful in orienting the nurse to newer methods of treatment, to the reactions of mentally ill patients, to technics of management and rehabilitation, and the role of various ancillary personnel working in the psychiatric unit, the book also defines qualifications needed for psychiatric nursing and the types of activities desired for this type of nursing care. A chapter is included on the use of art, literature, music, and dancing in psychiatric care. Bibliographies and review questions follow each chapter.

81

Nutrition in Health and Disease

By: **Lenna F. Cooper** (and others)

1958. 734 p. illus., tabs. 13th ed. J. B. Lippincott Co., E. Washington Sq., Philadelphia 5, Pa. $6.00.

This revision of a text long recognized as authoritative presents nutrition principles and practices brought up to date in accordance with the 1958 Recommended Dietary Allowances. New chapters have been added on "Food and the public health" (reviewing the current information on foodborne infections, food poisoning, deterioration, spoilage, and modern methods of food preservation) and "The patient and his nutritional problems" (patient attitudes toward food, feeding problems, and diet in relation to specific diseases, including chronic illness, diabetes, and heart disease). The chapter on diet in regard to diseases of childhood has been greatly expanded. Bibliographic references carefully selected and brought up to date are divided into professional and lay categories. The book contains, in addition, two indexes—one general, the other an index to individual recipes.

82

Seminar on Rehabilitation of the Physically Handicapped for Participants from Asia and the Far East, Solo, Indonesia, 26 August to 7 September, 1957 . . .

By: **United Nations**

1958. 158 p. (ST/TAA/Ser. C/32) Mimeo. Paperbound.

Contains lectures and discussions presented at the Conference organized by the United Nations and the government of India in cooperation with several international voluntary organizations in the field of rehabilitation. Principles and methods of modern rehabilitation covering the medical, economic, psychologic, and social aspects of disability were discussed. Administration and the role of various team members were also considered. Specific problems encountered in 13 participating countries were given attention; the report also contains the statements prepared by representatives of 12 countries on their respective rehabilitation programs. Papers by Dr. Henry H. Kessler included: "Causes and prevention of disability," "The role and place of medical rehabilitation in the rehabilitation process," and "Rehabilitation of the amputee." Mr. Donald V. Wilson gave two lectures on

"The education of public opinion" and "The role of voluntary organizations in rehabilitation."

Available from the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y.

83

Report of the Ministry of Health for the Year 1957; Part II, On the State of the Public Health . . . The Annual Report of the Chief Medical Officer

By: **Ministry of Health, Great Britain**

1958. 292 p. figs., tabs. (Cmd. 559) London, H. M. Stationery Office. Available in the United States from British Information Services, 45 Rockefeller Plaza, New York 20, N.Y., at $2.34 a copy.

Contains a resume of the important vital statistics for England and Wales for 1957, the epidemiology of various diseases, preventive measures employed, the current problems associated with tuberculosis, rheumatic diseases, cancer, and mental health. Other aspects of public health are also covered in the review of the year. Chapters 15, 17, and 20, dealing with recent trends in the care of young handicapped children, the Artificial Limb Service, and information on the blind and partially seeing will be of special interest to those who are in the rehabilitation field.

84

Poliomyelitis; Papers and Discussions Presented at the Fourth International Poliomyelitis Conference

By: **International Poliomyelitis Congress**

1958. 684 p. illus., figs., tabs. J. B. Lippincott Co., E. Washington Sq., Philadelphia 5, Pa. $7.50.

The Fourth Conference proceedings include discussions of many phases of poliomyelitis and the problems involved in care of the patient, but emphasis is on the preventive vaccine now in use throughout the world. New information is presented on enteric viruses producing diseases simulating poliomyelitis and on studies of viruses and cultures of mammalian cells. Basic problems of respiratory distress in patients with poliomyelitis, care of the severely affected patient, and group and home care of patients with respiratory or extensive paralysis during the postacute and rehabilitative phases are also covered. Reports of the official delegates to the Conference are given.

Rehabilitation Through Public Welfare Services

"ACCORDING TO WEBSTER, to rehabilitate is 'to invest or clothe again with some right, authority or dignity; to restore to a former capacity.' Welfare services are rehabilitative when they—

- Restore the disabled to usefulness or train them in new skills that enable them to become self-supporting.
- Encourage employers to hire the handicapped.
- Help a newly blinded person to accept his handicap and learn to live with it.
- Protect defenseless children from parental neglect or abuse.
- Locate a deserting father and encourage him to accept some responsibilty for the family he left behind.
- Provide foster care and good parental influences to children who have never known any real family life.
- Guide a young delinquent toward better patterns of behavior.
- Help an unmarried mother to understand some of her conflicting emotions and to make plans for her own future as well as for her child.
- Lead a family to better housing, child care resources, or medical and recreational facilities available in the community.
- Help a disabled father to maintain his position as head of the family, whether or not he is able to continue as breadwinner.
- Show a tired and discouraged client that someone is interested in his problems and will try to help with plans to improve the situation.
- Encourage the older person to find new interests, to live a useful life and to maintain his rightful place in society.

"These are some of the services that rehabilitate. Caseworkers in public welfare programs throughout the country perform these services every day."—*Editorial, in* Tennessee Public Welfare Record. *October, 1958.*

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

85

The Clinical Treatment of Juvenile Amputees, 1953-1956

By: New York University College of Engineering, Research Division. Prosthetic Devices Study

August 1958. 85 p. tabs. Mimeo. Spiral binding. (*Report no. 115.26C*) New York State Department of Health and New York University, New York, N.Y.

The clinical treatment during 1953-1956 of 159 upper extremity child amputees, 90 males and 69 females ranging from 10 months to 15 years of age, was investigated. They were 104 below-elbow, 36 above-elbow, 6 shoulder-disarticulation, and 13 bilateral cases. Forty-six were traumatic in etiology, the remainder congenital. The sample, drawn from 33 clinics in various sections of the United States and including children from rural and urban areas, appears representative in age, sex, amputation type, and geographical distribution.

The more than 90% accepting prostheses seemed to be well motivated, with realistic views of their disability and the restoration possible. In general they identified themselves primarily as normal, while recognizing their amputation. Another factor was a sense of security, based on a feeling of acceptance by others. A clear, unequivocal desire on the part of parents for the child's independence and prosthetic rehabilitation was significant in acceptance. Early fitting with comfortable, well-fitted, and properly functioning prostheses also was a great influence. Rejection of the prostheses, by less than 10%, was associated with insecurity, the development of substitutive skills prior to fitting, inability to cope with disappointment or failure, and unrealistic expectations. Parental influences leading to rejection included ambivalence of desire for the child's independence and prosthetic fitting and parental guilt. Poorly fitted or uncomfortable prostheses often led to rejection.

Prescription, checkout, and training practices were examined. The great majority did not require preliminary medical or surgical treatment. Such prefitting needs are substantially fewer than with adults. Prescribing components was generally similar to adult procedures, except as to size. Components are generally selected for functional requirements, but special size considerations supervene in respect to terminal device, wrist, and elbow. Personal judgment is most important, but within relatively broad age groups "typical" prescriptions could be described. At present a cosmetically acceptable functional hand is not available in child sizes, and no child below the age of 10 was fitted with one. Standards established for adult upper-extremity prostheses were applicable, with minor modifications, to the evaluation of children's arms. The minimum standards of appearance and comfort were regularly met. Cuffs, inverted Y straps, control systems of below-elbow prostheses, and above-elbow sockets most frequently presented an unsatisfactory appearance. Sockets and harnesses produced discomfort. The below-elbow cases generally met the force and range of motion standards. Significant numbers of above-elbow cases were limited in flexion and abduction at the glenohumeral joint and in terminal device opening and 90° forearm flexion and at the mouth. Substandard force transmission efficiency was a frequent problem.

Current checkout procedures are tedious and time-consuming, creating practical difficulties with young children. The development of a "functional" checkout system to evaluate children's arms by performance in self-motivating activities would seem worthwhile.

Training children to use prosthetic arms is a highly variable procedure. The policies governing the length of individual training sessions were also variable and did not consistently seem to be related to age, amputation type, or other seemingly germane factors. However, above-elbow amputees and inpatients received significantly longer training, and those wearing a prosthesis for the first time and girls had somewhat longer training than previous wearers and boys did. Only in the above-elbow group did those with short stumps receive longer training. Training goals and methods differ greatly from clinic to clinic. The equipment and facilities varied from the extremely simple to the elaborate. A division of responsibilty between occupational and physical therapists was frequently observed, the former handling upper extremity patients and the latter lower extremity patients. The evaluation of training is highly subjective and characterized by an absence of standards and reliable, objective measurement instruments. This was reflected in the varying amounts of training time given children. In the field of training, the overriding needs are for the establishment of more universally accepted training goals, determination of the most efficient training methods, and the development of

an adequate evaluation system and instruments to measure training achievement.

Conclusions and impressions derived from the study carry important implications for the direction and method of future research in the field of the clinical treatment of juvenile amputees. Four research areas offer possible rich returns: assessment of the influences of personality and environment; development of prescription criteria to guide the selection of components for children of varying sizes, ages, and afflictions; development of minimum standards of appearance, comfort, and function of prostheses for children; and formulation of a training system based on clearly established goals, efficient methods, and valid evaluation procedures.

86
Rehabilitation in Australia

By: **F. H. Rowe**

In: *Internatl. Labour Rev.* Nov., 1958. 78:5:461-475.

Since its beginnings 10 years ago, the Commonwealth Rehabilitation Service has demonstrated the value of rehabilitation to the disabled person and to the community. The Service's work, along with that of the voluntary organisations, has undoubtedly contributed to the growing interest of the medical profession and to the establishment of rehabilitation programmes. The uneven development of the programmes may be attributed to the nature of the country (54 percent of the people are in the six widely separated metropolitan areas of the mainland) and to the division of responsibility. The power to legislate for invalid pensions was given the Commonwealth in the Constitution, but health and hospital services are a responsibility of the six states. In 1946 the Constitution was amended to widen the Commonwealth's powers in health and social services. The states receive Commonwealth assistance in meeting maintenance costs and are provided capital grants for tuberculosis and mental institutions. Most of the state hospitals work under boards of medical and lay members. Little has been done until recently to coordinate and develop rehabilitation services and there has been little teaching in this field. Comprehensive services, attempted in only three states, are recent in origin and have lacked funds.

Organisations to aid the blind and the deaf and dumb have existed for many years. Since the late 1920's many voluntary organisations have been formed to meet the needs of disabled children. The postwar period has seen a remarkable growth of organisations for other special groups, especially children with cerebral palsy. These have established several excellent centres. In the past decade, associations have been formed to care for amputees, paraplegics, mentally retarded, and those handicapped by poliomyelitis and multiple sclerosis. These societies are represented on the Australian Advisory Council for the Physically Handicapped, established by the voluntary agencies.

The Commonwealth's Repatriation Department since its inception in 1917 has been responsible for the medical treatment of exservicemen with war service-connected disabilities. It established well-equipped hospitals, sanatoria, and artificial limb factories, and a limited vocational training scheme was conducted between 1917 and 1926. After World War II, the Department provided a wide range of benefits, including vocational training and re-establishment loans and allowances. In 1952 a separate training scheme covered disabled exservicemen unable to use previous training opportunities.

Since 1910 invalid pensions had been paid to permanently incapacitated or blind persons 16 years of age or more; in 1941 recommendations were made and the Old Age and Invalid Pensions Act was amended and a vocational training scheme introduced. In 1945 as an interim measure the Department of Social Services became responsible for the convalescent care and re-establishment of disabled exmembers of the armed forces not receiving benefits because their disabilities were not due to war service. In the next few years some 11,000 ex-service personnel were assisted, several rehabilitation centres were opened, trained staff were recruited, and valuable experience gained. A 1947 report on the scheme stressed the social and economic worth of rehabilitation and recommended development of a plan for civilians.

Dr. William M. Usdane's article "Employability of the Multiple Handicapped," featured in the January issue, is available in reprint form at 25c a copy. Please send payment with your order. Inquire for quantity rates.

In 1948 the Social Services Act provided for the introduction of a full-scale rehabilitation service for invalid pensioners and recipients of unemployment and sickness benefits who, without rehabilitation, were apt to be unemployable. Treatment, training, assistance in obtaining suitable employment, and financial help were provided for. Eligibility has since been widened. Though the Commonwealth Rehabilitation Service as it is now known does not extend to all the disabled in the community, it is the only Australian agency offering full-scale, nationwide rehabilitation services to large groups of disabled people.

The Service now has seven rehabilitation centres in or near the capital cities of the five mainland states. In Tasmania the centre administered by state hospital authorities is used. The largest, most up-to-date centre was completed in 1957 near Sidney. It has a treatment capacity of 150 and residential accommodations for 80. The centres provide on a residential and/or day attendance basis, under medical supervision, a rehabilitation pro-

gramme including physical, occupational, and speech therapy, prevocational assessment, and other essential services.

From the Service's introduction in 1948 through March, 1958, some 10,349 disabled men and women have been placed in employment after rehabilitation. The number accepted annually for rehabilitation has recently been about 1,500. This intake is affected by the capacity of centres and shortages of professional staff, principally therapists. Substantial waiting lists still exist for some centres. Expansion of capacity has not been possible, as funds available for capital works are limited. In the financial year 1956-1957 the Service's expenses were 568,063 pounds, met from the National Welfare Fund.

With current interest and increasing appreciation and acceptance of the value of rehabilitation, further development seems certain. This makes coordination and cooperation between rehabilitation agencies all the more important, and this at present is a matter of considerable concern to many leaders in the field.

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Effects of Inactivity

By: **Alma Murphy**, Ph.D.

In: *Rehabilitation of the Patient at Home or in Nursing Homes, p. 16-19.* 1958. 98 p. Mimeo. *(Continued Education Ser. no. 78)* Univ. of Michigan School of Public Health, Ann Arbor, Mich. $2.00.

Prolonged inactivity on the part of a patient severely or acutely disabled by trauma or disease may lead to permanent or additional unnecessary disability. Intelligent use of appropriate measures to maintain bodily function will decrease the time and cost of restoration of the patient to maximal independence. As the patient recovers, the level of activity should be increased but maintained within his reserve strength. The patient's ability to meet the demands placed upon his body increases with activity.

Muscle power and function. Muscle strength is maintained by causing the muscle to contract strongly, by working against resistance or weights, within the limits of the patient. If the muscle does not contract with force at frequent intervals, functional ability is lost and convalescence delayed. Appropriate exercises should be used.

Loss of mobility in joints. With impairment of blood supply to a joint or with trauma or infection, the thickening of connective tissue is hastened and range of motion limited. Joints not used will show changes. When immobilization or rest is not needed, the extremities should be moved through their full range to maintain mobility. Bed rest particularly affects the hips and knee joints, especially when the patient is in a soft bed in a semi-reclining or sitting position and pillows are used under the knees or head. The neck, hips, and knees become flexed, and the feet drop downward. Firm mattresses, bed boards, and foot boards to protect the feet from covers should be used. Sitting in a chair for long periods causes joint changes that interfere with the ability to walk in an upright position.

Circulatory deterioration. Normally circulation adjusts to changing states of the body (standing from a lying position, walking up stairs rapidly), but after confinement to bed the regulatory mechanisms become delayed or fail to respond or over-respond. After one week's confinement, a patient may be faint on standing, grow pale, perspire profusely, become restless, show congestion in his feet and legs, be lightheaded, or have pain and tingling in the feet. After longer periods of recumbency, these signs become more severe and recovery more prolonged. Postural unsteadiness results from decreased blood pressure, the resting heart rate is increased 10 beats per minute, and the pulse rate increases more (120 to 170 per minute) on exertion. In normal persons confined to bed for three weeks, the heart rate takes from 5 to 10 weeks to return to normal. In three weeks of recumbency, the cardiovascular function decreases 15 percent. Appropriate exercises should be given to minimize the degeneration of the circulatory regulating mechanisms.

Skin deterioration. Decubiti or ischemic ulcers are a continual threat to the debilitated patient, who sometimes has poor nutrition or circulation. Patients should be moved about, their positions changed frequently, or pressure removed in some way to prevent the breakdown of skin and tissues over bony prominences or at pressure areas.

Skeletal changes. Upon long confinement, the long bones become porous and weakened as a result of lack of weight-bearing stress. Calcium from the bones is excreted through the blood and the kidneys, resulting in kidney or bladder complications. When the period of bed rest may be shortened by use of preventive measures, the problem of osteoporosis can be minimized.

Metabolic changes. Inactivity causes the loss of essential mineral, steroid, and vitamin substances from the body. Nitrogen loss is greatest in cases of semistarvation or starvation plus bed rest but is also very high in patients with a fracture or gastric resection or with an infection such as meningitis. The source of the nitrogen may be muscle protein, plasma, or cellular deposits (soft tissue), and bones. This problem may be related to the state of nutrition as well as inactivity. High protein diet in most cases (except fractures) will reverse the nitrogen loss.

Efficient rehabilitation of the disabled patient can be expedited by the prevention of the deteriorating effects of inactivity and the preservation of functional abilities.

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Multiple Sclerosis: A Physiatric Approach to Management

By: **Kathryn J. McMorrow, M.D., M.P.H.** (*Michigan Multiple Sclerosis Center, 1800 Tuxedo, Detroit 5, Mich.*)

In: *J. Mich. Med. Soc.*, Nov., 1958. 57:11:1564-1566.

Any approach to management of multiple sclerosis must consider the emotional, social, and vocational problems, besides the physical. Fatigue is the most prominent complaint and difficult for the physician to deal with. If character disorder is associated or the family feels the complaint is used as a method of control, there should be both psychiatric casework and family counseling services in addition to counseling by the family physician. An explanation of the "energy budget" is useful in dealing with fatigue.

Observation of patients with ataxia suggests that, without treatment, the wide-based gait attempted for stability weakens hip flexor muscles. Lumbar lordosis increases and lumbosacral fascia tighten. The gluteus maximus and the gluteus medius muscles become overstretched and weak; ambulation is further impaired. With much time spent sitting or lying, general deconditioning of the musculature occurs, with less efficient use of respiratory muscles and increased fatigue. Physical treatment within the patient's tolerance to fatigue should be programmed. In this symptom complex, exercise should include: (1) stretching of the lumbosacral fascia, (2) straight leg raising, (3) pelvic tilting, (4) quadrupedal balance, (5) squatting balance, and (6) progressive resistive exercise for gluteus maximus and medius muscles. During exacerbation, strict bed rest is required.

Pyramidal tract deficits sometimes occur. When the anterior tibialis begins to lose function and clonus becomes troubling, a properly constructed short leg brace can do much. Stretching of the heel cord and other spastic muscles should become routine early in management.

Spastic paraplegia is a much more severe disability and management far more difficult. The patient with weakness and tremors and incoordination of the upper extremities should be taught wheelchair activities of daily living. One with a good trunk and little or no involvement in the upper extremities can be helped. Stretching of the spastic muscles and strengthening of the upper extremities, including the trunk and the latissimus dorsi, are of prime importance. The Keystone Splint allows the spastic patient to stand supported in the ischial region. While it is worn, ambulation in parallel bars for periods up to six months will strengthen the pelvic musculature and lower abdominal muscles. Generally ambulation is then possible with conventional crutches and short leg braces.

Lack of bladder control is very troublesome. Bladder infection is common. Every patient should have a urological workup with cystometrograms. Strengthening of the perineal musculature through muscle reëducation or with the perineometer should be attempted early. Bladder stones are not infrequent. In long periods of nonweight-bearing, there may be osteoporosis with the osteomalacia, and hormonal therapy may be needed. Treatment of sensory deficits remains frustrating. Phanodorm may benefit the severe tremors in certain individuals. Functional occupational therapy can improve coordination of upper extremities. Many with severe incoordination and intention tremor of the upper extremities become malnourished. The nutrition received should be investigated carefully, since some patients cannot communicate needs. This is especially important when feeding is left to unsupervised children. Constipation with fecal impaction is far more common than bowel incontinence.

Some helpful appliances are: (1) Collapsible wheelchair with foot plates, hand rims, and hand brakes. Eight-inch casters allow for turns in smaller areas. (2) Standing table, expensive to buy but easy to make. It reduces negative nitrogen balance and improves equilibratory and neurocirculatory reflexes in nonambulating patients. (3) Porta lift, which allows one person to lift a bedridden or heavy person. (4) Cane and crutches with suction cups for stability. (5) Bedside commode, especially when there is urgency.

Patients have anxieties about many things—the disability and effects on self and family, holding their jobs, and drugs and treatment. Answers to questions must be straightforward but sympathetic. Some will become depressed, isolate themselves, or have problems in the discipline of children because of fatigue and other limitations. Pastoral counseling is valuable. Specific social casework services are often needed. Patients with visual difficulties should be referred to "talking books." The physician may write the State Bureau of Social Aid for assistance through Aid to the Blind. He should inform the patient that a second income tax deduction is allowed for blindness. A state of medical indigency may be prevented by an early suggestion of sources of help, such as Aid to the Disabled, Aid to Dependent Children, and the State Office of Vocational Rehabilitation. The patient should be told of Social Security freezes. With the patient's permission, a frank talk between physician and employer can help the patient retain employment. Sometimes minimal concessions are all that is needed for the patient to keep on his job. A sustained program of management through the visiting nurse or health department can be of material benefit.

Chronic illness requires increasing cooperation of the family physician and others in the community. The busy physician, while he cannot integrate and correlate services, can initiate specific adjuncts to management and avoid patients' seeking nostrums and cultist kinds of treatment, which may result in complete medical and social indigency.

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Survey of Pupils in Schools for Physically Handicapped in London

By: **W. T. Palmer** and **Denis Pirrie, M.B., D.P.H.** *(Public Health Dept., London County Council)*

In: *Brit. Med. J.* Nov. 29, 1958. 5108:1326-1328.

A survey was made in 1957 to determine the reasons for admission of children to London's 17 schools for the physically handicapped. The diagnoses were coded under the *International Statistical Classification* (WHO, 1957). Of the 93 conditions recorded, cerebral palsy (312), poliomyelitis (240), and congenital heart disease (127) were the most common. Except for these large groups, the children had a wide range of conditions, with only one or two cases of some. The figures, it was felt, could not be used to measure the incidence of any particular condition in the population, as many handicapped children are in ordinary schools and many do not attend any school. However, the findings were important as a measure of the need for special educational provision.

Statistics derived from surveys made in 1928, 1951, and 1957 show that the population of the schools for physically handicapped fell more steeply (from 4,061 to 1,325) than the total London school population (from 639,000 to 443,000); the incidence of attendance at schools for the physically handicapped per 1,000 of school population in 1957 was less than half what it was in 1928. The most marked decrease in incidence of cases was found, as expected, in juvenile rheumatism and in nonpulmonary tuberculosis. Juvenile rheumatism fell from 1.96 per 1,000 through 0.6 in 1951 to 0.16 in 1957, and nonpulmonary tuberculosis from 1.14 through 0.40 to 0.16. In 1928 poliomyelitis was second only to rheumatism as a reason for admission, with an incidence of 1.21; in 1951 the incidence was 0.53 and in 1957 it was 0.54. In 1957 poliomyelitis was again second, but cerebral palsy led. The incidence of cerebral palsy rose from 0.49 through 0.72 to 0.77, while the number of cases increased from 314 to 342. This change may have been brought about by the trend toward admission of very severely handicapped children to the special schools.

The incidence of arthritis, progressive muscular dystrophy, kidney disease, and brittle bones increased, but not in large numbers. Congenital heart disease caused 251 admissions (0.39) in 1928 and 241 (0.59) in 1951, but by 1957 there were only 146 (0.33). To find the reasons for these variations would take a special inquiry. The incidence of disabilities due to injuries fell from 0.18 to 0.06 (26 children). Children who are amputees, for example, return to their ordinary schools after only a short stay.

Schools for the physically handicapped are usually single-storied, too often 30 to 40 years old, and not too well suited to their functions. Usually about 100 children are in a school, with not more than 20 in a class. Special coaches are used for conveyance. In 1928 no treatment was given at the schools, and children lost valuable time travelling and waiting. In 1951 a start had been made at providing physiotherapy at the schools; by 1957 it was available in all schools, along with speech therapy. Teachers of the deaf can visit schools where there are groups of deaf children with cerebral palsy. In old schools there is inadequate provision for these services, but in new schools planning is excellent.

There has been a double change over the years, some handicapped children entering normal school communities where previously they would have stayed in special schools and others attending special schools who would have remained in the home or hospital. It should not be assumed that all the decrease over the past 30 years is due to an improvement in the health of the child population; however, much of the change is due to just this. It is not that there are children with chorea or rickets in ordinary schools—there is no chorea, there is no rickets.

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Articles to Appear Soon in Rehabilitation Literature

ALTHOUGH THERE IS NO "Article of the Month" featured in this February issue, scheduled for early publication are—

Neurophysiologic Technics in Physical Therapy, by Sarah Semans, R.P.T.

Problems of Sensorimotor Learning in the Evaluation and Treatment of the Hemiplegic Patient, by Glenn A. Reynolds, M.D.

Special Education in European Countries, by Wallace W. Taylor, Ph.D.

Other articles in preparation by well-known authorities for subsequent issues are on such subjects as physical abilities testing, family role of the disabled mother, hypnotherapy in rehabilitation, brain injuries in children, and social factors in the lives of the employed handicapped.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION—MEDICAL TREATMENT

90. Mazet, Robert, Jr. *(V. A. Center, Wilshire and Sawtelle Blvds., Los Angeles 25, Calif.)*

Cineplasty; historical review, present status, and critical evaluation of sixty-four patients. *J. Bone and Joint Surg.* Dec., 1958. 40-A:6:1389-1400.

Until the establishment of Army and Navy Amputation Centers during World War II, cineplasty received little attention in the United States. Experience with problems of amputee rehabilitation and improved devices and technics have resulted in better functioning prostheses in patients who have had the operation. Historical literature in the field is found to contain fairly explicit descriptions of surgical technics; however, very little follow-up data and objective evaluation are included. Contemporary technics in tunnel construction are based on Sauerbruch's method but have been modified in some respects. Data from detailed follow-up studies of 64 patients are analyzed and critically evaluated; it was found that cineplastic muscle tunnels and prostheses made according to present technological methods in selected patients are generally adequate. Causes of failures in this series of patients are listed, as well as the prerequisites for successful use of cineplasty tunnels. Adequate screening by a prosthetic team would eliminate a number of such operations where the prognosis is poor.

APHASIA

91. New York University-Bellevue Medical Center. Institute of Physical Medicine and Rehabilitation

Understanding aphasia; a guide for family and friends, by Martha L. Taylor; foreword by Howard A. Rusk. New York, The Institute, 1958. 48 p. illus. (*Patient publ. no. 2*)

Although written by Mrs. Taylor, head of the Institute's Department of Speech and Hearing Therapy, this second pamphlet prepared for the use of patients and their families represents the combined experience of the Institute's staff in dealing with the aphasic patient. Information presented here should help to clear up misunderstandings in regard to the medical and psychologic aspects of the problem. Based on questions most frequently asked by families of the aphasic patient, answers are general in nature rather than technical or detailed. Causes and types of aphasia are explained, treatment described, and ways for the family to aid the patient pointed out. An appended section contributed by Miss Mary Switzer of the U.S. Office of Vocational Rehabilitation and Miss Jayne Shover of the National Society for Crippled Children and Adults explains services available for the aphasic patient under programs of both organizations.

Available from the Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16, N.Y., at 50¢ a copy.

See also 123.

ART

92. Gunter, L. H. *(V. A. Hosp., Hines, Ill.)*

Art is good medicine for disabled patients. *Modern Hosp.* Nov., 1958. 91:5:101-103.

A brief comment on the value of occupational therapy as a specific treatment medium in physical medicine and rehabilitation. Consisting mainly of illustrations of art work in various forms produced by patients at Hines V.A. Hospital, the article describes how art exhibits from the occupational therapy department can be used to stimulate public interest in rehabilitation. Publicity releases are carefully planned to stress the treatment objectives rather than the finished article.

ARTHRITIS—OCCUPATIONAL THERAPY

See 146.

ARTHRITIS—PROGRAMS

93. Robinson, Harold S. *(960 W. 27th St., Vancouver 9, B.C., Canada)*

The cost of rehabilitation in rheumatic disease. *J. Chronic Diseases.* Dec., 1958. 8:6:713-718.

Results of a survey of the financial cost of rehabilitation in rheumatic patients admitted to a rehabilitation center in Vancouver are reported. A brief review of the facilities and program of the center is given. The study was concerned only with male patients. While return to active employment was not the primary aim of the program, it was used as one means of measuring the program's effectiveness. Estimates of the cost of the program offered 36 patients are compared with increased earned income over a two-year period subsequent to the patients' discharge from the rehabilitation center. Basic cost of the program was found to have been recovered in increased income earned by the patients. An interesting fact reported was the better work prognosis in patients with spondylitis than in those with rheumatoid arthritis.

ASTHMA

See 153.

ASTHMA—PSYCHOLOGICAL TESTS

94. Neuhaus, Edmund C. *(967 W. Shelley Rd., North Bellmore, N.Y.)*

A personality study of asthmatic and cardiac children. *Psychosomatic Med.* May-June, 1958. 20:3:181-186.

A paper based on a doctoral dissertation, New York University, 1953. Two major hypotheses were investigated: (1) the chronic asthmatic child exhibits a personality pattern differing from that of the normal healthy child; (2) the asthmatic child shows a personality pattern that is related either to the specific character of his illness or to the fact that he is chronically ill. Conclusions based on test results were that asthmatic children, as a group, were significantly more maladjusted or neurotic than children of the normal control group and their personality was characterized by traits of anxiety, insecurity, and dependency. These findings agree with those of previous studies in the literature. Child cardiacs also exceeded normals in the degree of neuroticism and dependency feelings exhibited. There are no previous psychometric studies on child cardiacs, however, to confirm the findings. Lack of significant differences in test results between asthmatics and cardiacs indicates that the personality picture of the asthmatic child cannot be wholly ascribed to the nature of the asthmatic disorder.

AUDIOMETRIC TESTS

95. Kodman, Frank, Jr. *(Audiology Clinic, Univ. of Ky., Lexington, Ky.)*

An investigation of hearing loss in mentally retarded children and adults, by Frank Kodman, Jr. (and others). *Am. J. Mental Deficiency.* Nov., 1958. 63:3:460-463.

A report of an investigation of the incidence of hearing loss in a residential school for mentally retarded children and adults. In addition to collecting data on incidence, the authors hoped to be able to formulate adaptable pure tone technics for testing large samples of mentally retarded subjects. (For results of the latter see the article in *Exceptional Children*, Mar., 1958, annotated in *Rehab. Lit.*, May, 1958, #452.) Incidence of hearing loss in the total sample of 189 persons tested was 21%; in the age group from 7 to 19 incidence of loss was 19%. Further research is necessary to verify the magnitude of the difference between hearing sensitivity in the mentally retarded child and the child with normal learning ability.

BLIND

96. Himes, Joseph S. *(N. Carolina Coll., Durham, N.C.)*

Changing attitudes of the public toward the blind. *New Outlook for the Blind.* Nov., 1958. 52:9:330-335.

In same issue: Changing attitudes toward blindness from the point of view of 20/20, Charles G. Ritter, p. 336-338.

Evidence points to definite changes in traditional attitudes toward the blind and their status in the general social structure. Experiments in mass economic relief during times of depression have helped to clarify the dependency status of the blind and their immediate needs for rehabilitation. More objectivity in organizing services and new approaches to the social and economic problems of the blind are resulting in public realization of the possible productive capacities of blind persons.

Superficial attitudes and misconceptions regarding the exact definition of blindness need to be corrected if the blind person's individual needs are to be recognized and met. While not denying the existence of total blindness, public education programs should make known the fact that most blind persons retain some degree of residual vision. However, Mr. Ritter believes public relations programs will be effective only when the blind are successful in raising the social and behavioral standards of the more backward members of their blind group.

BLIND—U.S.S.R.

97. Klinkhart, Emily J. *(Am. Foundation for the Blind, 15 W. 16th St., New York 11, N.Y.)*

Some observations on work for the blind in the U.S.S.R. *New Outlook for the Blind.* Dec., 1958. 52:10:386-389.

An account of the author's visit to three of the 15 republics in Russia and her observations on research for the blind being conducted there, educational provisions for the blind and deaf-blind, and the employment possibilities for this group of the handicapped.

BLIND—EMPLOYMENT

98. Stone, J. R. *(Oldsmobile Div., General Motors Corp., Lansing, Mich.)*

Industry looks at the blind. *Internatl. J. Educ. of the Blind.* Dec., 1958. 8:2:52-58.

The Director of Safety for the Oldsmobile Division of General Motors defines qualifications and abilities that industry expects from the blind as employees. Vocational counselors will find the discussion and practical suggestions helpful in individual or classroom guidance of the blind seeking employment. Mr. Stone approaches the problem of employer acceptance of the handicapped, job placement and training, and competitive conditions of industry in a realistic manner.

99. Zimmerman, A. Alfred *(Calif. Bur. of Voc. Rehab., State Dept. of Education, Sacramento 14, Calif.)*

Developments in the darkroom. *J. Rehab.* Sept.-Oct., 1958. 24:5:19.

Cooperative plans whereby blind persons are trained to process x-ray films have proved that this is a resource that the rehabilitation counselor of the blind should utilize more widely in their placement. Experience in California's vocational rehabilitation program has shown there is no service commonly expected of a darkroom technician that cannot be performed satisfactorily by a properly qualified and trained blind person. Characteristics of applicants for this type of training, the role of the rehabilitation counselor in the training process, and adaptations in work routines are discussed.

BLIND—PSYCHOLOGICAL TESTS

100. Parmelee, Arthur H., Jr. *(Dept. of Pediatrics, Univ. of Calif., Los Angeles 24, Calif.)*

Mental development of children with blindness due to retrolental fibroplasia, by Arthur H. Parmelee, Jr., Margery Gilbert Cutsforth, and Claire L. Jackson. *A.M.A. J. Diseases of Children.* Dec., 1958. 96:6:641-654.

A report of a study to determine the possible mentally retarding effects of prematurity and/or oxygen poisoning on children with blindness due to retrolental fibroplasia. Incidence of mental retardation among 38 children with blindness due to retrolental fibroplasia was compared with the incidence among 22 children whose blindness was due to other causes. Findings of the study confirm those of

previous studies—that incidence of mental retardation is no greater among children with retrolental fibroplasia than in children blind from other causes. However, incidence of mental retardation in both groups studied was found to be higher than is generally reported. Factors that might have influenced the findings are discussed and case summaries of children in both groups are presented. Some of the pertinent literature in the field is reviewed.

BONES—GROWTH

101. Kottke, Frederic J. *(860 Mayo Memorial, Univ. Hospitals, Minneapolis 14, Minn.)*

Studies on the disturbance of longitudinal bone growth: II. Effect of the sympathetic nervous system on longitudinal bone growth after acute anterior poliomyelitis, by Frederic J. Kottke, Glenn Gullickson, Jr., and Mildred E. Olson. *Arch. Phys. Med. and Rehab.* Dec., 1958. 39:12: 770-779.

Findings of a study of the rate of longitudinal bone growth in the lower extremities of 17 children who had paresis of one leg and nearly normal strength in the other leg after acute anterior poliomyelitis. Also studied was the effect of long-term administration of a sympatholytic drug, a dihydrogenated ergot alkaloid compound, on longitudinal bone growth in 14 children. Findings support the hypothesis that after poliomyelitis there is reflex hyperactivity of the sympathetic nervous system in response to cold, which results in vasoconstriction in the extremity and inhibits epiphyseal bone growth.

See also 125.

CAMPING

102. Goodwin, Henry E.

How handicapped campers can fit into regular programs. *Camping.* Dec., 1958. 30:9:18-19.

Describes adaptations in the camping program when handicapped children are included, outlines a typical daily schedule, and discusses briefly the fixed activities that handicapped campers enjoy. Crafts, athletics, a nature program, storytelling, dramatics, music, swimming, and campfire singing in the evening are activities recommended with adaptations.

CEREBRAL PALSY

103. Rushworth, Geoffrey *(28 Fitzroy Sq., London, W. 1, England)*

Latest research that may help the spastics. *New Scientist.* Oct. 16, 1958. (3) p.

A brief review of advances in research in cerebral palsy as discussed by 50 world experts who met recently in England to discuss new developments and exchange information on the many aspects of cerebral palsy. There is better understanding of how muscular contractions are coordinated into movement patterns and the role of muscle spindles in the process; studies are being conducted to determine how damage to the brain causes spasticity. Surgical technics have been devised to treat patients with involuntary movement disorders.

CEREBRAL PALSY—BIOGRAPHY

See 77.

CEREBRAL PALSY—DIAGNOSIS

104. Woods, Grace E. *(21, Downs Cote View, Westbury-on-Tyre, Bristol, England)*

The early diagnosis of infantile cerebral palsy. *Public Health* (London). May, 1958. 72:2:54-60.

Early signs of cerebral palsy may be varied according to the brain damage present; the author stresses the vital importance of early detection of the condition. Motor defects are the most obvious sign but, where the fundamental defect is in the brain, other abnormalities are sometimes evident, such as microcephalus or hydrocephalus, uncontrolled eye movements persisting after the first few weeks of life, convulsions or frequent twitching, feeding difficulties, lack of understanding of speech, deafness, and mental backwardness. Often the neonatal history or early signs of physical abnormality, usually defects in the normal maturation of movement patterns, will be a clue to the true diagnosis. Early signs observed in spastic quadriplegia, paraplegia, and hemiplegia are described as well as those seen in athetosis and the ataxias.

CEREBRAL PALSY—ETIOLOGY

105. Flanagan, Eleanor *(Dept. of Anatomy, Duke Univ. Med. Center, Durham, N. C.)*

An experimental study in the neonatal guinea pig on a possible cause of cerebral palsy, by Eleanor Flanagan and R. Frederick Becker. *Phys. Therapy Rev.* Nov., 1958. 38:11:756-758.

Because oversedation of the pregnant mother with barbiturates administered near term has been suggested as a possible cause of cerebral palsy in the infant, the writers experimented with guinea pigs to test the effects of oversedation with sodium pentobarbital on the young animals produced. Many of the newborn showed neurological characteristics attributed to the cerebral palsied child. Implications of the findings are that inadvertent misuse of barbiturates to insure a painless delivery may be a potent factor in the etiology of cerebral palsy.

CEREBRAL PALSY—MEDICAL TREATMENT

106. Banks, Henry H. *(721 Huntington Ave., Boston 15, Mass.)*

The correction of equinus deformity in cerebral palsy, by Henry H. Banks and William T. Green. *J. Bone and Joint Surg.* Dec., 1958. 40-A:6:1359-1379.

Data from a follow-up study of 132 cerebral palsied patients who had undergone orthopedic surgery for the correction of equinus deformity support the authors' belief that such orthopedic procedures are effective in the treatment of spastic cerebral palsy. The most satisfactory procedure in this series of patients was a sliding lengthening of the heel cord. Essential to effective results are adequate postoperative management, long-term support out of equinus position at night through the growing period, and an exercise regimen to develop balanced muscle function between agonist and antagonist. Stabilization of the foot, an effective measure in the correction of varus or valgus deformity and in simplifying control of the foot in older individuals, should not be used to correct severe equinus deformity. Article is extensively illustrated.

CEREBRAL PALSY—PARENT EDUCATION

107. Sykes, M. Kathleen

The problems and needs of parents of cerebral palsied children. *Cerebral Palsy Bul.* Autumn, 1958. 3:6-15.

A report of a research project to survey the family backgrounds of a group of children with cerebral palsy who attended a special school in England. In home interviews by a social worker, parents revealed general experiences and anxieties common to families of the cerebral palsied. Comments and suggestions made by parents on services that could be of assistance are included. Children were severely handicapped and between the ages of 8 and 15.

CEREBRAL PALSY—SPEECH CORRECTION

108. Burgi, Ernest J. *(Dept. of Speech, Univ. of Neb., Lincoln 8, Neb.)*

Predicting intelligibility of cerebral palsied speech, by Ernest J. Burgi and Jack Matthews. *J. Speech and Hear. Research.* Dec., 1958. 1:4:331-343.

Procedures for use in predicting the intelligibility of the speech of young adult cerebral palsied subjects are described. A test of the consonant articulation of each subject yielded data that provided both simple and complex articulation predictor measures. Prediction of intelligibility by each of eight articulation measures was evaluated.

CEREBRAL THROMBOSIS

See 71.

CHILDREN (DEPENDENT)

109. Reiman, M. Gertrude *(3877 N. 41st St., Milwaukee 16, Wis.)*

Considerations about mental deficiency in planning for adoption. *Am. J. Mental Deficiency. Nov.,* 1958. 63:3:469-472.

The current trend toward very early placement of adoptive children calls for reappraisal of diagnostic technics in determining the suitability of the placement. Proper caution demands that infants should be kept under observation for several weeks, at least, so that a team of observers—the pediatrician, social worker, boardinghouse mother, and the psychologist—can more readily judge the nature of the child's development and recognize any signs of possible mental retardation.

CHRONIC DISEASE—STUDY UNITS AND COURSES

110. Michigan. University. School of Public Health

Rehabilitation of the patient at home or in nursing homes. Ann Arbor, Univ. of Mich. School of Public Health, 1958. Mimeo. 98 p. *(Continued Education ser. no. 78)*

A compilation of the papers presented and the discussions held at the Short Course on Rehabilitation of the Patient at Home or in Nursing Homes, held in May, 1958, at the University of Michigan. The course was a project included in the Michigan Department of Health's training program and was designed to serve official health, voluntary agency, and nursing home personnel. Subjects of the papers ranged from the philosophy and objectives of rehabilitation to the specifics of long-term care of patients, the technics of physical medicine, and the particular needs of the patient with chronic illness. (See #87.)

Available from The Continued Education Service, 109 S. Observatory St., Ann Arbor, Mich., at $2.00 a copy.

CLEFT PALATE—MEDICAL TREATMENT

111. Slaughter, Wayne B. *(55 E. Washington St., Chicago 2, Ill.)*

A new surgical concept for repair of congenital clefts of lip and palate, by Wayne B. Slaughter (and others). *Surg. Clinics N. Am.* Aug., 1958. 38:4:945-958.

Describes a method of repair for harelip and cleft palate that is directed primarily toward preservation of the growth potential of the middle third of the face, while, at the same time, it restores the lost function and improves the cosmetic appearance of the face. Timing of surgery, technics of repair, pediatric care, and types and methods of administration of anesthetics are discussed.

CLEFT PALATE—SPEECH CORRECTION

112. Van Hattum, Rolland J. *(Kent Co. Board of Education, 316 Ottawa St., N.W., Grand Rapids, Mich.)*

Articulation and nasality in cleft palate speakers. *J. Speech and Hear. Research.* Dec., 1958. 1:4:383-387.

An article based on a Ph.D. dissertation, Pennsylvania State University, 1954. The study was an outgrowth of clinical observations, supported by some research, that listener judgments of hypernasality in cleft palate speakers are influenced by the speakers' misarticulations. Data on 16 of the 20 subjects tested provided evidence, in the writer's opinion, to support the hypothesis. It seemed especially significant to him that none of the subjects judged to have better articulation was judged to have more nasality in sentences than on vowels.

CONVALESCENCE—RECREATION

113. Sanford, George L. *(Newington Home and Hosp. for Crippled Children, Newington, Conn.)*

Hospital recreation; therapy or fun? by George L. Sanford and Jerry Curtis. *J. Health, Phys. Educ., and Recreation.* Nov., 1958. 29:8:25-26.

Discusses recreational activities offered at the Newington Home and Hospital for Crippled Children to provide enjoyment, opportunity for socialization, and the learning of skills of a recreational nature. The writers believe that such programs in the hospital should be purely recre ational and not primarily for therapeutic purposes.

DEAF—RECREATION

114. Chicago Hearing Society

Group work with hearing impaired children; report on a three-year group work demonstration project for deaf and hard of hearing children, by Mary L. Thompson, Jane Bull, and Selma Zucker Holme. Chicago, The Society. c1958. 57 p.

A report relating actual experiences and conclusions in a project to integrate normal children and children with hearing loss in a recreational program. Group activities with younger children were organized at a neighborhood settlement house with leadership provided by staff mem-

bers of the Chicago Hearing Society. The community program was attempted in the hope that it could improve the social adjustment of the deaf and hard of hearing, promote understanding of their needs among professional workers, and provide guidelines for future programs throughout the country. Experiences illustrate some group work methods used with children with hearing loss.

Available from Chicago Hearing Society, 30 W. Washington St., Chicago 2, Illinois.

DEAF—SPECIAL EDUCATION

115. Streng, Alice *(1413 E. Courtland Pl., Milwaukee 11, Wis.)*

On improving the teaching of language. *Am. Annals of the Deaf.* Nov., 1958. 103:5:553-563.

Since little or no specific research information is available concerning the development or use of language by deaf children, the writer has made an examination of methods used in learning foreign languages, some recent books on structure and grammar in the English language, and the psychological theories involved in the learning process. She shows how general procedures devised for foreign language teaching can be applied, with some sound psychological principles, to teaching of the deaf.

See also 120; 144; 161.

EMPLOYMENT (INDUSTRIAL)

See 98.

EPILEPSY

116. Patterns of Disease. Dec., 1958.

Entire issue devoted to the subject.

Consisting mainly of statistical data with brief explanatory text, this issue of *Patterns of Disease,* a publication for use by the medical profession, gives facts on the causes of epilepsy, types of seizures, hereditary aspects of the disease, prognosis, mortality rates, facilities for treatment, the legal and economic aspects of epilepsy. A regular feature of the publication, on infectious disease patterns of the preceding month, is also included with a statistical breakdown of five communicable diseases and state-by-state trends. The rates of incidence for selected cities are given.

Available to members of the medical profession from Parke, Davis & Co., Detroit 32, Mich.

EPILEPSY—MEDICAL TREATMENT

117. Williams, Denis *(National Hosp., Queen Sq., London, England)*

Drugs in treatment of epilepsy. *Brit. Med. J.* Nov. 8, 1958. 5105:1155-1156.

Reviews the value of various drugs used in the treatment of epilepsy considered in its widest application (including recurring discrete disorder of sensation, behavior, or consciousness of any sort due to cerebral disturbances). Types of epilepsy are classified and the fact stressed that correct diagnosis is necessary before assigning drugs to control seizures. Types of anticonvulsant drugs found to be most practical and useful in ambulant patients are discussed, with indications of dosage and contraindications where complications occur.

EXERCISE

118. Harpuder, Karl *(150 E. Gun Hill Rd., New York 67, N. Y.)*

The Eighth John Stanley Coulter Memorial Lecture: Training and fitness; concepts and problems in rehabilitation. *Arch. Phys. Med. and Rehab.* Dec., 1958. 39:12: 751-755.

Fitness for the aged and handicapped can be defined in the same terms as that for the average man if certain limitations are recognized. Physiologists have made studies of the problems of fitness and training in athletes but it is recognized that these standards cannot be applied to average or handicapped persons. No data are available beyond clinical impressions on the effects of chronic arthritis, peripheral vascular disease, or chronic neurologic disease on physical performance. Research should be conducted to determine the specific physiologic effects of daily recreational and occupational activities. The purpose of training for the aged and handicapped is to increase functional fitness in their daily living activities; it should be individually designed to meet the patient's particular needs, with due consideration given to psychologic factors.

See also 121.

HARD OF HEARING—PROGRAMS

119. Wallace, Helen M. *(Univ. of Minn. School of Public Health, Minneapolis 14, Minn.)*

Evaluation of community hearing services. *Eye, Ear, Nose & Throat Month.* Dec., 1958. 37:12:833-838.

Types of services needed by patients with hearing impairment are discussed briefly and two methods for the evaluation of services outlined. An analysis of patients served and a study of the services themselves can yield an accurate picture of the effectiveness of what is being provided in the community. Both are essential to the recognition of unmet needs and for the improvement of services.

HEALTH EDUCATION

120. Lewis, Bertha *(Rackham School of Special Education, E. Mich. Coll., Ypsilanti, Mich.)*

Health education for the deaf at the elementary level. *Am. Annals of the Deaf.* Nov., 1958. 103:5:564-571.

A paper planned for the use of student teachers preparing to teach the deaf. Constant daily observation is necessary in determining the health needs of deaf pupils; record keeping should be systematic. Instruction in health teaching is equally important for the deaf child as for the child with normal hearing; procedures for teaching health subjects as units on the elementary level can be planned. The classroom teacher can also contribute much toward the mental health of her pupils. Knowledge of community and school services available for the correction of remediable disabilities should be passed on to parents by the well-informed teacher.

HEART DISEASE

121. Kottke, Frederic J. *(860 Mayo Memorial, Univ. Hospitals, Minneapolis 14, Minn.)*

Studies of cardiac output during the early phase of rehabilitation, by Frederic J. Kottke (and others). *Postgrad. Med.* May, 1958. 23:5:533-544.

A report on a series of studies to obtain information on the requirements for cardiac output of various types of activities commonly performed by cardiac patients in the hospital or during convalescence. The acetylene method for estimating arteriovenous oxygen difference was used. A classification of the relative cardiac stress produced by various activities is based on the endurance level of the normal adult cardiovascular system. Activities are graded from minimal to heavy. Findings of the studies can be applied in planning a program to restore the cardiac patient to his greatest usefulness. The activities studied also might be used to test the working capacity of the damaged heart.

See also 155.

HEART DISEASE—BIBLIOGRAPHY

122. U.S. Public Health Service

Selected references on cardiovascular disease; an annotated bibliography for nurses. Rev. ed. Washington, D. C., Govt. Print. Off., 1958. 72 p. *(Public Health Bibliography ser. no. 15. Public Health Serv. publ. no. 472)*

References included are those of interest to the nurse in her professional capacity and for the patient's education. Material is arranged in subject categories covering anatomy and physiology, the main types of cardiovascular disease, diagnostic procedures, emotional aspects, nutrition, public health programs, rehabilitation, patient education, visual aids, and periodicals. An author index and index of publishing agencies complete the bibliography. Annotations are brief but concise.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 30c a copy.

HEART DISEASE—PSYCHOLOGICAL TESTS

See 94.

HEMIPLEGIA

See 71; 146.

HOMEBOUND—SPECIAL EDUCATION

123. Wallace, Viola *(Readers' Advisory Service, Cincinnati Public Library, Cincinnati, Ohio)*

Guided home study program. *Adult Leadership.* Nov., 1958. 7:5:125-128, 148.

A unique project in adult education, the only program of its kind sponsored by a public library, is being conducted by the Cincinnati Public Library to provide individual guidance in acquiring the equivalent of education from the elementary level on through college and beyond. Originally the Library supplied reading outlines with appended reading lists; now it offers more personal guidance, closer supervision, and greater attention to the preparation of materials to be used in the program. An unusual request for help came from an aphasic man who was in need of retraining and personal interest in his rehabilitation. Small classes for young mothers, for those whose working hours did not allow attendance at night schools, and for the foreign-born have proved highly successful.

HYDROCEPHALUS

124. Laurence, K. M. *(Dept. of Morbid Anatomy, Hosp. for Sick Children, Great Ormond St., London, W.C. 1, England)*

The natural history of hydrocephalus. *Lancet.* Nov. 29, 1958. 7057:1152-1154.

A report on a follow-up study of 182 unselected and unoperated cases of hydrocephalus seen by one surgeon during the past 20 years. The study was an attempt to determine the incidence of spontaneous arrest of hydrocephalus and to evaluate the physical and mental states of the survivors. Findings of this investigation suggest a more hopeful prognosis, since in this series an appreciable number have not only survived but are now growing into useful citizens capable of earning a living. Considering the rate of spontaneous arrest in this sample, the reported results of surgery in hydrocephalus, in the author's opinion, may have to be reassessed.

LEG

125. Blount, Walter P. *(324 E. Wisconsin Ave., Milwaukee, Wis.)*

Unequal leg length in children. *Surg. Clinics N. Am.* Aug., 1958. 38:4:1107-1123.

An article concerned with the actual shortness of bones in growing children, due to congenital anomaly or trauma, and the surgical methods for correction. Dr. Blount stresses the necessity for recognizing, first, the contractures and angular deformities causing functional shortening as opposed to structural shortening. These should be corrected before measures are taken to overcome structural shortening. Five methods for correcting structural shortening are discussed; in cases where the shortening is too great for equalization by the patient's own tissues, amputation should be done early with prosthetic replacement.

See also 101; 106.

MENTAL DEFECTIVES

126. Shackelford, John W. *(3400 N. Eastern, Oklahoma City, Okla.)*

Mental retardation; the problem. *J. Okla. State Med. Assn.* June, 1958. 51:6:300-302.

In same issue: The etiology of mental health retardation, T. R. Pfundt, p. 303-306, 357.—The physician's responsibility in mental retardation, G. R. Russell and Robert K. Endres, p. 307-312.—Habilitation of mentally retarded, Paul C. Benton, Julia McHale, and Lillian Whitmore, p. 313-322.

Research in the field of mental retardation should be concerned with defining factors responsible for reproductive failure, whether the failure be abortion, premature birth, cerebral palsy, mental retardation, or congenital malformation. More attention should be given to the problem of early recognition, evaluation, and habilitation of children born with these disorders of the central nervous system, which place them in the category of retarded children.

Dr. Pfundt presents the basic structure of a preliminary classification outline for mental retardation, a special project of the American Association on Mental Deficiency. The article by Drs. Russell and Endres reviews the scope

of the problem of mental retardation on the national level and its relation to other handicaps. Responsibilities of the physician in the management of mentally retarded patients are listed and discussed. The article by Dr. Benton and others is designed to serve as a guide to the physician in his role as a personal advisor or participant in community groups interested in helping mentally retarded children and their families. It is mainly a discussion of the educational and vocational aspects of planning for the mentally retarded child.

See also 78; 109.

MENTAL DEFECTIVES—MINNESOTA

127. Minnesota. Advisory Board on Handicapped, Gifted, and Exceptional Children

The trainable retarded child in Minnesota; a report of the . . . June, 1958. St. Paul, Minn. State Dept. of Education, 1958. 35 p. tabs. Mimeo.

A thorough study of the characteristics, developmental potential, and research on trainable mentally retarded children was made by a subcommittee of the Minnesota Advisory Committee on Exceptional Children in an attempt to define the public responsibility for these children and to make recommendations for a suitable program of service. Experience in other state programs was reviewed and is reported in the appendix. Minnesota's current provisions for the trainable retarded are discussed and considerations for expanded programs in the home, school, institution, and community studied. Recommendations for expanded and improved services in this area, drawing on existing state and local resources, are made.

Available from the Minnesota State Department of Education, 517 Commerce Bldg., St. Paul 1, Minn.

MENTAL DEFECTIVES—DIAGNOSIS

128. Kirman, Brian H. *(Fountain Hosp., London, England)*

Early disturbance of behaviour in relation to mental defect. *Brit. Med. J.* Nov. 15, 1958. 5106:1215-1219.

Mental abnormality can seldom be predicted accurately in the young child on the basis of specific behavior disorders. Only severe mental defect can be recognized at an early age. More often the social background is adverse and responsible for retardation of development. The predictive value of tests of children under the age of 5 years is very low, in the author's opinion. Early assessment and attention are helpful where there are conditions that can be treated, but too much attention to delayed development at an early stage can sometimes cause undue anxiety in parents and affect the child's subsequent development.

See also 95; 100; 124.

MENTAL DEFECTIVES—EMPLOYMENT

129. Chernov, Brina E. *(Div. of Voc. Rehab., Providence, R. I.)*

Facing the challenge of mental retardation, by Brina E. Chernov and Edward J. Carley. *J. Rehab.* Sept.-Oct., 1958. 24:5:8-10.

Rhode Island turned its attention to the vocational problems of the retarded in August, 1955; by October, 1956, a program to provide transitional simulated work experience was in operation to train the retarded for employment in the community. A cooperative venture of the Division of Vocational Rehabilitation and Community Workshops of Rhode Island, it offers work evaluation and a training program focused on personal adjustment of the client. Administration of the program, personnel involved, comprehensive nature of the services, and role of the vocational counselor in the program are described.

MENTAL DEFECTIVES—PROGRAMS

130. Benoit, E. Paul *(Governor Bacon Health Center, Delaware City, Dela.)*

Responsibility of the community for the mentally retarded. *Am. J. Mental Deficiency.* Nov., 1958. 63:3:396-402.

The community should be aware of the needs of parents of young mentally retarded children, the necessity for training the retarded in the preschool years, of the needs of school-age retarded children, and finally, of needs of those of employable age. The whole logic of public assistance, as Dr. Benoit sees it, lies in diminishing the size of the public burden by developing the potential of the individual and protecting the economic independence and productivity of the family unit. While society should assume responsibility for such services as classes and sheltered workshops, other facilities can be sponsored by individual volunteers, civic groups, and the voluntary agency.

MENTAL DEFECTIVES—SOCIAL SERVICE

131. Begab, Michael J. *(U.S. Children's Bur., Washington 25, D. C.)*

A social work approach to the mentally retarded and their families (from the standpoint of the institution). *Am. J. Mental Deficiency.* Nov., 1958. 63:3:524-529.

In same issue: A social work approach to the mentally retarded and their families (from the standpoint of community agencies), John Carter, p. 529-534.—A social work approach to the mentally retarded and their families, Ella A. Dye, p. 534-536.

The social problem of mental deficiency calls for a shared responsibility between all levels of government. The state could expand its sphere of responsibility by establishing diagnostic and treatment centers, expanding special education facilities, and developing vocational rehabilitation services. Day nursery care, summer camps, recreational facilities, and parent counseling should be the responsibility of the local community. Through such a pooling of efforts, many of the retarded could be rehabilitated in their own homes without the need for rehabilitation in a public institution.

Mr. Carter undertakes an evaluation of community agency services to mentally retarded children and their families and of the relationship of caseworkers in community agencies to those working in institutions. Services available in Connecticut and, especially, in Hartford are described.

Miss Dye makes a brief analysis of the two preceding papers, summarizes the discussion, and makes some comments on contributions that schools of social work can make to the solution of social problems caused by mental retardation. It is suggested that changes are necessary in social work educational programs.

MENTAL DEFECTIVES—SPECIAL EDUCATION

See 73; 75; 170; 173; 180.

MENTAL DISEASE

132. Appleby, Lawrence *(Osawatomie State Hospital, Osawatomie, Kan.)*

For mental patients physically impaired; a hospital program of service, by Lawrence Appleby and Barbara E. Bliss. *J. Rehab.* Sept.-Oct., 1958. 24:5:16-17, 47-49.

In same issue: Rehabilitation of mental hygiene patients, Ernest Grover and James J. Calvert. p. 20-21, 30.

Describes a rehabilitation program within a state hospital for mental patients planned to meet the needs of those with physical disabilities; the project was first used to rehabilitate the partially or totally blind. Preliminary planning for patients with other physical handicaps has begun. Successful results in three patients are described.

Drs. Grover and Calvert (V.A. Hosp., Albuquerque, N. Mex.) discuss an outpatient program for acute psychiatric patients formerly maintained in neuropsychiatric hospitals but now able to live in the community. The use of tranquilizers and the support given by the Mental Hygiene Clinic have resulted in marked improvement in three patients; one has even reached the goal of employability.

See also 142.

MENTAL DISEASE—MEDICAL TREATMENT

133. Freeman, Walter *(91 Main St., Los Altos, Calif.)*

Prefrontal lobotomy; final report of 500 Freeman and Watts patients followed for 10 to 20 years. *South. Med. J.* June, 1958. 51:6:739-745.

A final report on 500 prefrontal lobotomy patients followed for 10 to 20 years; in the author's opinion, more than 98% of the patients in this series were disabled when the operation was undertaken. Of the surviving patients 70 to 80% are living outside the hospital and about 40 to 50% are usefully occupied either in the home or in outside employment. Failure of patients to show improvement after the operation is attributed to emotional deterioration, progress of disease, relapse due to inadequate operation, posterior incisions or operative complications, accompanying physical disease, organic brain disease, and onset of mental disorder in childhood. In Dr. Watts' discussion of the report he notes that it is significant from the neurophysiologic viewpoint that a reduction in the amount of cerebral tissue has not prevented a substantial number of patients from engaging in socially valuable activities.

134. Freeman, Walter *(91 Main St., Los Altos, Calif.)*

Psychosurgery; present indications and future prospects. *Calif. Med.* June, 1958. 88:6:429-434.

The more widespread use of ataractic drugs in the treatment of severe psychotic states has more or less eclipsed lobotomy as a method of treatment. However, variations and adaptations of the operation can still be used in certain well-defined conditions with benefit. Positive indications for operation are listed and discussed. Objections to psychosurgery and poor results obtained are considered. Lobotomy is advised in cases where the patient does not show sustained improvement after a year of active treatment by other indicated means. Further research in the area of the temporal lobes is suggested in the hope of developing procedures that will suppress hallucinations.

MENTAL DISEASE—NURSING

See 80.

MENTAL DISEASE—PROGRAMS

135. Muth, Lee T. *(Chief, Social Work Serv., V.A. Hosp., Huntington, W. Va.)*

After care services for the mentally ill; a world picture. Huntington, W. Va., The Author (1958). 81 p. Mimeo.

Because very little information was available in the literature on after care programs for the mentally ill, the author made a questionnaire survey of mental hospitals in the United States and foreign countries to determine what services were currently being provided for discharged patients. Replies revealed a wide range in the quantity and quality of such services. The main portion of the study is given over to a description of the development and current status of after care services in the United States, provided by government and voluntary agencies. Services provided by the general practitioner, public health nurse, and rehabilitation worker are discussed. A list of hospitals participating in the study and a selected bibliography are included.

MENTAL HYGIENE

136. Lassen, T. J. *(Lower Peninsula Mental Hygiene Clinic, 1023 25th St., Newport News, Va.)*

About handicapped children. *Va. Med. Month.* July, 1958. 85:7:392-394.

Reactions of handicapped children to their disability vary widely; the author speculates on the reasons for such differences, noting patterns of thought in society as a whole and in parents especially. Attitudes of parents and siblings can accentuate the handicapped child's "differentness"; where the child is secure in his relations to others, he can adjust to and find acceptance in the group. Personality development in the handicapped is influenced by the same factors that determine personality of the normal child, the author believes. General counseling with parents of the handicapped child can benefit the child as well; the mental hygiene clinic offers psychotherapy for the child and collateral treatment for parents where they are needed.

MONGOLISM

137. Baroff, George S. *(1731 Harrison Ave., Bronx 53, N. Y.)*

Current theories on the etiology of mongolism. *Eugenics Quart.* Dec., 1958. 5:4:212-215.

According to the accumulated findings of many studies the etiology of mongolism apparently requires both a gene-specific vulnerability and an unfavorable intrauterine milieu. The author points out that the genetic mechanism involved is not apt to be a simple one, since the low familial incidence rate militates against a single-factor type of inheritance. The theory of a new single-factor mutation for every case of mongolism is, in his opinion, equally implausible. Etiological background factors in mongolism are considered; results from studies of twins and estimates of familial incidence are mentioned briefly. A striking aspect of mongolism is its relationship to maternal age; the nature of the underlying reproductive deficiency has not yet been defined. 22 references.

MULTIPLE SCLEROSIS—MEDICAL TREATMENT

138. Critchley, MacDonald *(King's College Hosp., Denmark Hill, London, S.E. 5, England)*

Drug treatment of parkinsonism. *Brit. Med. J.* Nov. 15, 1958. 5106:1214-1215.

A discussion of the relative merits of some comparatively new drugs used in the treatment of parkinsonism; drugs are classified as antispasmodics and antihistaminics. Dosage, side effects, and the psychiatric symptoms that infrequently accompany use of the drugs are described. Drugs used in treating parkinsonism before 1947 are still recommended for patients unable to tolerate the newer drugs; used in combination with the antispasmodic drugs, they may prove quite useful. The use of surgical methods to alleviate symptoms of parkinsonism probably will not influence the scope of treatment with drugs.

139. Kremer, Michael *(National Hosp., Queen Sq., London, England)*

Disseminated sclerosis. *Brit. Med. J.* Dec. 13, 1958. 5110:1463-1464.

Although there is at present no specific treatment for multiple sclerosis, symptomatic relief can be provided through the use of various drugs, the relative value of which is described. Treatment of hypertonus and spasms, vertigo, sphincter disturbances, pain, and pressure sores is considered. An essential part of treatment is the maintenance of morale in the patient and his relatives; the provision of mechanical aids can often aid in the restoration of useful function.

MUSCLES

140. Von Werssowetz, Odon F. *(Texas Rehab. Center, Box 58, Gonzales, Tex.)*

Rehabilitation of tendon transfers. *Military Med.* Dec., 1958. 123:6:428-436.

Indications for tendon transfer, standardized technics, and basic principles to be observed in the evaluation and selection of patients for surgery are discussed. Factors that must be evaluated before surgery is attempted are listed; immediate postoperative care is essential in the rehabilitation program. Physical medicine technics used in reeducating muscles after immobilization are discussed at some length.

MUSCLES—TESTS

141. Rondot, P.

Mesure de la force des réactions musculaires a l'étirement passif au cours des raideurs pathologiques par lésions cérébrales, (by) P. Rondot, J.-C. Dalloz, (and) G. Tardieu. *Rev. française d'études cliniques et biologiques.* 1958. 3:6:585-592.

A report of research being conducted at the Hospital Raymond Poincare, Garches, France, with the aid of a grant from the United Cerebral Palsy Research and Educational Foundation. The authors have attempted to define more precisely the different characteristics of cerebral muscular hypertonicity (spasticity, rigidity, and athetotic spasm), as well as to measure them in elbow extension in 27 subjects, either normal or with pathological hypertonicity. Simultaneous electrical recordings were made of the speed of extension and the force applied. For each subject 300 to 350 observations of extension at different speeds were made. Results are given in conclusion. Text is in French with a résumé in English.

MUSIC THERAPY

142. Sherwin, Albert C. *(Payne Whitney Clinic, 525 E. 68th St., New York 21, N. Y.)*

A consideration of the therapeutic use of music in psychiatric illness. *J. Nerv. and Mental Dis.* July, 1958. 127:1:84-90.

A review of the theoretical formulations concerning the response to music shows that thus far there is little convincing evidence, either theoretical or experimental, to explain why music may have therapeutic value. It is believed that psychopathology may affect the response to music, sometimes in a distinct and predictable manner. In psychotherapy, music is used as a form of occupational therapy or recreational therapy and would appear to have some value. A more effective use of music in the treatment of patients with psychological disorders may emerge when there is better understanding of the relation between the response to music and psychopathology.

NATIONAL HEALTH SURVEY—1956-

143. U.S. Public Health Service

Health statistics from the U.S. National Health Survey; concepts and definitions in the Health Household—Interview Survey. . . . Washington, D. C., Govt. Print. Off., 1958. 29 p. figs. *(Public Health Serv. publ. no. 584-A3. Ser. A-3)*

Describes the basic questionnaire and its supplements, interviewing methods, and concepts of morbidity, disability, and medical and dental care as applied in the Health Household-Interview Survey—one of a series of surveys employed to obtain health statistics on the American people under the program of the U.S. National Health Survey. A classified list of terms used in the reports, with definitions, is included. Two earlier publications in this series covered the origin and program of the National Health Survey (see *Rehab. Lit.*, Aug., 1958, #898) and the statistical design of the Health Household-Interview Survey.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 30c a copy.

NURSERY SCHOOLS

144. Slankard, Harriet *(Dept. of Hearing and Speech, Univ. of Kan. Med. Center, Kansas City, Kan.)*

Teaching the deaf child to think. *Volta Rev.* Dec., 1958. 60:10:523-527.

Methods used to teach preschool deaf children to reason and to develop their ability to think are described; all have been employed with success at the University of Kansas Medical Center's Preschool for the Deaf. By using his sense of touch, smell, taste, and seeing, the deaf child's perceptions are sharpened and he learns to relate old experiences with new ones.

NUTRITION

See 81.

OCCUPATIONAL THERAPY

145. Ayres, A. Jean *(Univ. of S. Calif., Occupational Therapy Dept., University Park, Los Angeles 7, Calif.)*

Basic concepts of clinical practice in physical disabilities. *Am. J. Occupational Ther.* Nov.-Dec., 1958. 12:6:300-302, 311.

A clarification and justification of the concept that the essential and distinctive quality of occupational therapy is purposeful function, defined as the use of the motor system as a means toward accomplishing a goal that is inherent in the nature of the activity demanding the function. These goals are seen as separate from but vital to the therapeutic objectives involving range of joint motion, coordination, endurance, strength, use of a prosthetic or orthotic device, or performance of the activities of daily living. The author urges that scientific and theoretical bases must be sought for the use of purposeful activity in the rehabilitation process. Theoretical confirmation of the concept is provided in a brief review of the literature on function in man. Lack of fully effective use of the principle lies not in the limitations of occupational therapy but in the fact that knowledge of the principle is still in the early stages.

146. Jewett, Barbara *(Detroit Memorial Hosp., 1420 St. Antoine St., Detroit 26, Mich.)*

Occupational therapy procedures in rehabilitation medicine as applied to hemiplegia and arthritis. *J. Mich. State Med. Soc.* Nov., 1958. 57:11:1553-1554, 1584.

An activities program for arthritic and hemiplegic patients should provide for development in self care activities, avocational and hobby interest, prevocational exploration, and the establishment of work tolerance. Psychological reactions to disability arising from arthritis and hemiplegia necessitate a positive approach by the therapist. Helpful procedures and the proper therapeutic environment are discussed.

147. Rood, Margaret S. *(Box 274, Univ. of S. Calif., Los Angeles 57, Calif.)*

Every one counts. *Am. J. Occupational Ther.* Nov.-Dec., 1958. 12:6:326-329.

Eleanor Clark Slagle Lecture.

A discussion of the physical, emotional, intellectual, and professional growth and development of the occupational therapist. Miss Rood notes that in growth and development it is important that there be stimulation from without and within so that autogenetic or self-igniting facilitation and inhibition be developed.

148. Smith, Norma *(Milwaukee Children's Hosp., 721 N. 17th St., Milwaukee 3, Wis.)*

Occupational therapy in a pediatric section. *Am. J. Occupational Ther.* Nov.-Dec., 1958. 12:6:306-309, 313.

An awareness of the sequences in a child's development can aid the occupational therapist in planning a treatment program that will allow the child to progress normally within his developmental pattern. Activities should be chosen to fit the individual child's stage of development; those that are too simple offer no challenge and are not therapeutic or diversional. Types of activities that offer both diversion and therapeutic benefits are discussed.

See also 92.

OLD AGE—MEDICAL TREATMENT

149. Mazow, Bernard *(4118 Fannin St., Houston, Tex.)*

Visual problems of the aged. *Am. J. Optometry.* July, 1958. 35:7:360-368.

A discussion of some of the physical, physiological, pathological, psychological, social, and emotional problems of senescent patients who consult the optometrist. Methods for the clinical handling of such patients are described, with the author stressing that understanding of problems other than those associated with visual care is necessary.

OLD AGE—NURSING CARE

150. Owen, Ruth Edison *(Detroit Visiting Nurse Assn., Detroit, Mich.)*

Campus living for the aging, by Ruth Edison Owen, Thelma Malone, and Shirley O'Connell. *Am. J. Nursing.* Dec., 1958. 58:12:1676-1678.

Kundig Center, formerly a traditional social service agency in Detroit providing a housing registry, job counseling, and recreation, has expanded its services to provide the advantages of institutional living. Clients are helped to find rooms with suitable families within walking distance of the center; their days are spent at the center, which offers meals, recreation, and a form of family life. Duties of the public health nurse, who is in attendance two hours a week, are discussed. The plan has resulted in clients maintaining as much independence as they can manage with whatever protection they need.

PARALYSIS AGITANS—MENTAL HYGIENE

151. Chafetz, Morris E. *(32 Fruit St., Boston 14, Mass.)*

The role of psychiatry in the treatment of Parkinson's disease. *Geriatrics.* July, 1958. 13:7:435-440.

While the theory of parkinsonism as a psychogenic disease occurring in specific personality types has been refuted, it is well recognized that emotional and stressful factors do intensify the symptoms. The personality of the patient will influence, to a great extent, his reaction to the disease. The author discusses the various psychological responses to sudden and gradual onset of the disease, later reactions, and adjustment problems. The most useful treatment of parkinsonism involves a consideration of both the neurologic impairments and the emotional disturbances. A healthy doctor-patient relationship that leads to an understanding of the patient's problems, together with a realistic program of daily living and medication, can offer the patient reassurance. Group therapy is also of value in allowing patients to ventilate their fears and anxieties.

PARAPLEGIA—BIOGRAPHY

See 76.

PARAPLEGIA—MEDICAL TREATMENT

152. Kent, Herbert *(Pasteur Med. Bldg., 1111 N. Lee St., Oklahoma City, Okla.)*

Results in spinal cord injuries with early physical medicine and rehabilitation. *J. Okla. State Med. Assn.* July, 1958. 51:7:402-405.

A report on 16 patients with spinal cord injury studied between January, 1956, and January, 1958, at the Univer-

sity Hospitals, University of Oklahoma Medical Center. All injuries were traumatic in origin; the majority were the result of automobile accidents. Gunshot wounds, diving accidents, and falls accounted for the remainder. In cases where patients were given early and sustained comprehensive rehabilitation services, more than 67% achieved satisfactory results. The basic principles of rehabilitation employed in the series of patients are outlined. Results indicate that successful rehabilitation can be accomplished in the majority of such cases; many will eventually be employable.

PARTIALLY SIGHTED

See 149.

PHYSICAL EDUCATION

153. Scherr, Merle S. *(803 Atlas Bldg., Charleston, W. Va.)*

Physical conditioning program for asthmatic children, by Merle S. Scherr and Lawrence Frankel. *J. Am. Med. Assn.* Dec. 13, 1958. 168:15:1996-2000.

Describes experiences with a program of physical activities planned to supplement active treatment of children with bronchial asthma. Included in the program were basic breathing technics, postural exercises, gymnastics, and adaptation conditioning or confidence building activities (combatives). The program is adaptable to any city with YMCA or equivalent facilities with a qualified physical instructor willing to learn the basic essentials of bronchial asthma and the problems it presents. Specific exercises used are described. Successful results with 25 children have been achieved; in addition to improved physical condition, the children have shown better emotional adjustment.

PHYSICAL MEDICINE

154. Wing, Herman *(Dr. Watkins, Mass. Gen. Hosp., Boston 14, Mass.)*

Some medicolegal aspects of physical medicine and rehabilitation, by Herman Wing and Arthur L. Watkins. *Arch. Phys. Med. and Rehab.* Dec., 1958. 39:12:761-765.

Presents a brief outline of medical jurisprudence and its application, followed by a discussion of professional liability and responsibilities of the physician and other personnel in the hospital and rehabilitation center. The legal aspects of disability evaluation, the writing of medical reports, and relationships with statutory and administrative agencies such as Workmen's Compensation Boards and Rehabilitation Commissions should be thoroughly understood by the physician working in the field of rehabilitation. The total care concept of medical rehabilitation calls for awareness of administrative and socioeconomic factors affecting the patient's medical progress.

POLIOMYELITIS

See 84.

POLIOMYELITIS—MEDICAL TREATMENT

See 101; 140; 160.

POLIOMYELITIS—SPEECH CORRECTION

See 179.

PREGNANCY

155. Kaufman, Jack M. *(618 David Whitney Bldg., Detroit, Mich.)*

The current status of the pregnant cardiac, by Jack M. Kaufman and Paul E. Ruble. *Annals Internal Med.* June, 1958. 48:6:1157-1170.

Improved prognosis for the cardiac patient who is pregnant can be attributed to better understanding of the physiology of pregnancy, improved medical management, and modern heart surgery. When indicated, surgery should be done even during pregnancy, the authors believe. Data from their experience in the management of such patients support this optimistic viewpoint.

See also 137.

PREMATURE BIRTH

156. Dann, Margaret *(525 E. 68th St., New York 21, N.Y.)*

The development of prematurely born children with birth weights or minimal postnatal weights of 1,000 grams or less, by Margaret Dann, S. Z. Levine, and Elizabeth V. New. *Pediatrics.* Dec., 1958. 22:6:1037-1053.

A report of part of a long-range study of prematurely born children with low birth weights who were discharged alive from the Premature Nursery of the New York Hospital. Observations are given on the physical, mental, and social development of 73 children, 36 of whom weighed 1,000 grams or more at birth but whose weight fell to 1,000 grams or less during the neonatal period. Data provided only a partial answer to the question of the premature child's chances of developing into a healthy individual who can function well in the community. In this series of children, physical health was good at the time of follow-up, with a marked paucity of neurologic defects. As a group, they exhibited a tendency to catch up in height to normal standards for chronological age, but often not until after 4 years of age. The incidence of eye defects, especially myopia and strabismus, was high. A wide range in IQ (59 to 142) was found; the very high incidence of serious maternal complications might well have influenced the outcome. However, no relationship was found within the group between lower IQ and complications of pregnancy and delivery, with the possible exception of toxemia and cesarean section. Historic and social data and findings on physical and psychometric examinations are evaluated.

157. Prognosis for children of low birth weight.

British Med. J. Dec. 6, 1958. 5109:1397-1398.

An editorial review that reports briefly the findings of a study of premature babies in Great Britain and their subsequent physical and intellectual development. Similar studies made in recent years are also noted. The need for well-planned research in this field is emphasized.

See also 100.

PROFESSIONAL ETHICS

158. Riemer, Delilah *(V.A. Hosp., Bedford, Mass.)*

Code of ethics. *Am. Arch. Rehab. Therapy.* Oct., 1958. 7:1: (i.e. 6:3:) 17-24.

A review of rules of ethics that all therapists seem to have in common in their relationships with the physician,

the patient, other therapists, workers in ancillary services, and the general public. Conflicts that arise in day-to-day administration of services to patients are viewed realistically in relation to the high ethical code of medical practice. The article is written with the educational therapist in mind; the responsibilities and status of this profession are still not clearly or generally understood. The discussion should help clarify ethical standards of practice.

PSYCHOLOGY

159. Maritz, J. S. *(Dept. of Labour, Johannesburg, S. Africa)*

The psychological aspects of rehabilitation. *Rehab. in S. Africa.* Sept., 1958. 2:3:93-98.

Disability may be said to have a subjective meaning or psychological effect for the patient, determined by the previously existing personality of the patient. A classification of reactions to physical disability by Leopold Bellak is included; the author then goes on to illustrate how organic disability is capable of affecting or precipitating psychologic maladjustment. The role of "body image" and the unconscious in the production of psychologic problems is discussed more fully. The psychologist on the rehabilitation team can aid in the analysis of mental reaction to disability, in determining prognosis for success in rehabilitation, in resolving the patient's maladjustment, and in evaluation of patient's employability. All technics developed by psychology can be brought to bear on counseling of the handicapped, whether it be clinical or vocational counseling. Special adaptations in administering psychologic tests, in handling the patient, and interpreting results must take into consideration factors influencing response.

See also 136; 172.

PSYCHOTHERAPY

160. Cath, Stanley H. *(Dept. of Psychiatry, Box C, Mass. Gen. Hosp., Fruit St., Boston, Mass.)*

The role of the body-image in psychotherapy with the physically handicapped, by Stanley H. Cath, Erik Glud, and Howard T. Blane. *Psychoanalytic Rev.* Jan., 1957. 44:1:34-40.

Clinical observations are presented concerning the process of reorganization or reintegration of body-image, drawn from the authors' experience in working with respiratory poliomyelitic patients. These observations have implications for the handling of patients with other diseases or injuries that result in permanent disability. All disabled persons experience problems in dealing with the trauma, the need to deny, the regression and depression characteristically observed. Later the patient must learn to justify the discrepancy between his body-image and his body-structure. The meaning of the illness must be clarified both in the patient's mind and in the minds of family members. By strengthening the patient's intellectual and rational defenses and reducing his anxieties, the therapist can minimize the use of inhibiting and restricting denial.

READING

161. Griffin, Barbara *(1545 St. Paul St., Rochester, N.Y.)*

Reading evaluation; a continuing study. *Volta Rev.* Nov., 1958. 60:9:476-477, 506.

A report of a study to evaluate reading levels and problems of pupils at the Rochester School for the Deaf, consisting of a testing program and remedial and research programs. Methods of the testing and remedial programs and areas of research being explored are discussed briefly. Definite conclusions have not been drawn as yet from the data collected but the writer offers some tentative deductions in regard to the relationship of reading attainment, intelligence, and early environmental factors. The problem of reading retardation appears to differ from individual to individual and calls for a variety of technics and materials to meet individual needs.

See also 75.

REHABILITATION

162. Aagaard, G. N. *(School of Med., Univ. of Wash., Seattle 5, Wash.)*

Rehabilitation. *Northwest Med.* Aug., 1958. 57:8: 997-1000.

A general discussion of the problems, treatment, results, and costs of rehabilitating persons with chronic major disabilities. The author includes statistics from rehabilitation studies to illustrate the extent of the problem on the national level, results of rehabilitation programs, the permanence of results, and the social and economic value of rehabilitation. In conclusion Dr. Aagaard gives briefly some suggestions for planning a rehabilitation program, emphasizing the need for close cooperation between the hospital and the comprehensive rehabilitation center. The program at the University of Washington Medical School and Hospital is sketched. The paper was presented at the Conference on Rehabilitation, University of Oregon Medical School, February, 1958.

163. Heyman, Clarence H. *(2676 Berkshire Rd., Cleveland Heights 6, Ohio)*

Rehabilitating the rehabilitation concept in the general hospital. *Hospitals.* Dec. 16, 1958. 32:24:41, 55-56, 60, 104.

It is not possible for every general hospital to provide adequate and comprehensive rehabilitation services, but they should participate in those phases of rehabilitation insofar as their facilities for the diagnosis and treatment of disease and disability make this feasible. Supplemental work in rehabilitation involving vocational testing, work evaluation, and vocational training can be done by affiliation with some large central training center with patients drawn from all hospitals in a given area. The author differentiates between the purposes and activities of various therapies and their place in the general hospital program.

164. Rogers, Eugene J. *(1664 41st St., Brooklyn 18, N.Y.)*

Principles and objectives in the comprehensive care of chronic illness. *G.P.* Dec., 1958. 18:6:112-115.

An outline to guide the family physician in planning more extensive rehabilitation programs for the chronically ill patients, it serves as a procedural routine for a more thorough evaluation. Better planning for short-term and long-range goals results when a thorough physical evaluation is made, followed by therapeutic measures to prevent medical and psychiatric complications. Reeducation and training in daily living activities and self care, the use of assistive devices, relearning communication skills and

walking all help the patient to become independent again. The author recommends the use of all available community resources in the rehabilitation of chronically ill patients.

REHABILITATION—CANADA

165. Desmarais, M. H. L. *(Municipal Hospitals, Winnipeg 13, Man., Canada)*

Rehabilitation in Manitoba, by M. H. L. Desmarais and W. N. Boyd. *Canad. J. Public Health.* July, 1958. 79:2: 292-296.

Current estimates of physically handicapped persons in Manitoba place the number at approximately 20,000, of whom an unknown number require rehabilitation and present a challenge to the community and the medical profession. The authors discuss the organization of rehabilitation services in the province since the appointment in 1954 of a provincial coordinator of services. A provincial rehabilitation commission, its members representing various professions and agencies, made a study of needs and offered recommendations for additional services. The Society for Crippled Children and Adults in Manitoba was designated as the Central Rehabilitation Agency for the province. Administration of the programs and coordination of efforts of other agencies responsible for rehabilitation of the tuberculous, blind, and industrial accident victims and treatment of Indians are discussed. Data on results of rehabilitation from the economic viewpoint are included. Future plans for increased services are projected.

166. Dunlop, Edward

Rehabilitation for the disabled in Canada; a plan for national action. Toronto, Canadian Arthritis and Rheumatism Soc., 1958. 26 p. Mimeo.

Based on working papers that the author prepared several years ago for the National Advisory Committee on the Rehabilitation of Disabled Persons, this report summarizes the needs of the disabled in Canada for rehabilitation services and makes recommendations for the setting up of a nationwide rehabilitation program. Suggestions for the probable and possible functions of the government in implementing rehabilitation services on national and provincial levels are given. The role of the voluntary agency is considered also. Organizational, financial, and legislative aspects of organizing a comprehensive, nationwide program of services are discussed.

Available from the Canadian Arthritis and Rheumatism Society, 900 Yonge St., Toronto 5, Canada.

REHABILITATION—TEXAS

167. Von Werssowetz, Odon F. *(Tex. Rehab. Center, Gonzales Warm Springs Foundation, Box 58, Gonzales, Tex.)*

Rehabilitation problems of the physically handicapped child in Texas. *Texas State J. Med.* July, 1958. 54:7: 484-488.

In his presidential address to the Texas Physical Medicine and Rehabilitation Society in 1958, Dr. Von Werssowetz outlined the areas of service in a comprehensive rehabilitation program for children and recommended adequate utilization and expansion of services, diagnostic and treatment services to be made available to every child without restriction, complete diagnostic evaluation by a team of specialists and ancillary personnel, periodic re-evaluation and adequate follow-up in home communities by public health nurses or social workers, and better liaison for normal schooling of the physically handicapped child. He suggested also that inadequate state laws should be modernized and adequate funds be made available for both emergency and long-term needs.

REHABILITATION—ADMINISTRATION

See 154.

REHABILITATION—FINANCE

See 93.

REHABILITATION—PERSONNEL

See 147; 158.

REHABILITATION—PROGRAMS

168. Miller, William J. *(District Voc. Rehab. Office, Tampa, Fla.)*

Community coordination for rehabilitation. *J. Rehab.* Sept.-Oct., 1958. 24:5:13-15.

Greater awareness of the vocational needs of the physically handicapped and recognition of the fact that no one agency can provide all the services necessary for total rehabilitation have resulted in heavy demands on the state vocational rehabilitation agency for services. The writer discusses how a wide variety of community agencies can coordinate their individual services to provide for the needs of the handicapped and what the rehabilitation counselor's role in community planning entails.

REHABILITATION—STUDY UNITS AND COURSES

169. Morgan, Cecil W. *(Springfield Coll., Springfield, Mass.)*

The workshop method in education. *J. Assn. for Phys. and Mental Rehab.* Sept.-Oct., 1958. 12:5:157-159, 166.

An evaluation of the use of the workshop method in education, particularly as it relates to the training of in-service personnel in various rehabilitation disciplines. Springfield College has offered five such workshops since 1955, covering the contribution of physical education, recreation, and education to total rehabilitation of the handicapped. In addition, two others of a more general nature dealing with new developments in the rehabilitation of the cerebral palsied have been offered. Attendance at the workshops varied from 15 to 30 participants each. Objectives and procedures of the workshops are discussed. Results indicate that professional growth is achieved, personal communication and cooperation are increased, and the effectiveness of this type of training has been noted.

See also 82.

REHABILITATION CENTERS—LEGISLATION

See 79.

RELIGION

170. Agee, J. Willard

Lest the least be lost; character education of the retarded. *Am. J. Mental Deficiency.* Nov., 1958. 63:3: 490-494.

The Union College-Character Research Project of Schenectady, N.Y., is attempting to develop a curriculum for use with mentally retarded persons, aimed at giving knowledge basic for Christian character, Christian attitudes, and the development of behavioral patterns that are mentally wholesome and socially acceptable. Through a "drama-type" educational approach, the retarded are to learn and be helped to make specific application of character dynamics to their life experience. Such a curriculum has value in research and is intended to deal with individual limitations in the group setting.

SHELTERED WORKSHOPS

See 129.

SOCIAL SERVICE (GROUP WORK)

See 114.

SOCIAL SERVICE (MEDICAL)

171. Cooper, Ruth *(School of Soc. Welfare, Univ. of Calif., Berkeley, Calif.)*

Trends in medical social work in the United Kingdom and the United States. *Soc. Service Rev.* Dec., 1958. 32:4: 387-399.

Changes and current trends in the practice of medical social work in Great Britain and in the United States are compared in the light of developments in medicine and medical practice. Changes in medical practice have had an effect on the administration of medical care in both countries. Differences in the educational preparation of medical social workers in both countries are noted, as well as the relationship of medical social work to the profession of social work as a whole.

172. Savard, Robert J. *(Soc. Service Dept., The Clinical Center, Natl. Institutes of Health, Bethesda, Md.)*

Casework and resistance to vocational rehabilitation. *Soc. Casework.* Dec., 1958. 39:10:564-570.

A discussion of a particular reaction to permanent disability displayed by some vocational rehabilitation clients—the desire of the individual to return to his previous nondisabled state. The defense mechanism of denial and flight from reality can hinder the acceptance of realistic vocational goals and cause the patient to react negatively to the vocational counselor. A rationale is presented for appropriate casework services with such patients; methods are suggested for referral for vocational rehabilitation counseling.

SPECIAL EDUCATION

173. Boyer, Ruth Gasink

How to make your special class a success. *Minn. J. Educ.* Dec., 1958. 39:5:15-17.

In same issue: School for the trainable, Maynard C. Reynolds. p. 9-10, 22.

Factors that contribute to the success of special education programs are discussed; the cooperation of the community, school administrators, and teachers is vital if results are to be achieved. Selection of the teacher and pupils for the special class must be done with care. The ideal arrangement of the classrooms for special instruction in both academic and living skills is considered. Adapted teaching technics in a flexible program can meet the needs of individual pupils who have not been able to succeed in the normal classroom.

The article by Mr. Reynolds summarizes the highlights of a report by the State Advisory Board on Handicapped, Gifted, and Exceptional Children on the particular responsibilities of communities for services to trainable severely retarded children in Minnesota.

174. National Education Association

Exceptional children. *N.E.A. J.* Dec., 1958. 47:9: 607-623.

Contents: Square pegs in round holes, Howard A. Rusk.—The emotionally disturbed, Fritz Redl and Stanley Jacobson.—The hard-of-hearing, Robert M. Benson.—The partially seeing, Lorraine Galisdorfer.—The crippled, Frances A. Mullen.—The slow learner, Agnes Mahoney.—The trainable but noneducable; whose responsibility? I. Ignacy Goldberg and William M. Cruickshank.

A feature section offered to help teachers who have exceptional children in the normal classroom. The education of physically, mentally, or emotionally handicapped children poses problems and calls for adaptations in methods, for resourcefulness, and for patience. Articles are contributed by authorities in the field of medicine, psychology, and special education.

Reprints of this special feature are available from the National Education Association, 1201 16th St., N.W., Washington 6, D.C., at 30¢ a copy (less in quantity orders of 10 or more).

See also 73; 74; 75.

SPECIAL EDUCATION—GREAT BRITAIN

175. Holroyde, C.

The handicap from within. *Special Educ.* Nov., 1958. 47:5:16-19, 56.

The author, Advisor for Special Schools in Liverpool, delivered this paper as his presidential address to the Special Schools Association. He reviews educational provisions in Great Britain for the blind, the deaf, the educationally subnormal (including the "problem" child and the emotionally maladjusted), and the physically handicapped. Stressed throughout the discussion is the great need for personal human service to the handicapped by the nonhandicapped, especially those in the educational professions.

SPECIAL EDUCATION—NORTH CAROLINA

176. North Carolina. Division of Special Education

Teamwork practices with handicapped children . . . proceedings of the Seventh Annual North Carolina Conference Special Education and Second Annual North Carolina Conference on Handicapped Children, December 8, 9, and 10, 1955, sponsored by . . . in cooperation with the Nemours Foundation. Raleigh, The Division, n.d. 115 p.

Proceedings contain the edited addresses given at the Conference, as well as brief summaries of eight group discussions dealing with special education for handicapped children.

Contents: Special education looks forward, Herbert Koepp-Baker.—Meeting the needs of partially seeing children in special classes and in the regular classroom, Franklin M. Foote.—The program of the Nemours Foundation,

A. R. Shands, Jr.—Education of the handicapped as related to other phases of community life, Leonard W. Mayo.—Some problems and current practices in providing for trainable children with mental retardation, Darrel J. Mase.—Special education in North Carolina; present and future, Charles F. Carroll.—Problems of the epileptic child, Hans Lowenbach.—New horizons in special education, Romaine P. Mackie.—Something old, something new in education, Arthur S. Hill.

Discussion groups considered teamwork practices with partially seeing children, the hard-of-hearing, the mentally retarded, the orthopedically handicapped, the emotionally disturbed, and children with speech disorders. Occupational opportunities for the mentally retarded and community resources for special education also received attention.

SPECIAL EDUCATION—DIRECTORIES

See 72.

SPEECH CORRECTION

177. FitzSimons, Ruth *(38 Mystic Dr., Warwick, R.I.)*

Developmental, psychosocial, and educational factors in children with nonorganic articulation problems. *Child Development.* Dec., 1958. 29:4:481-489.

Reports a study made to determine whether speech-handicapped children differed from normally speaking children in ways other than in the speech disorder syndrome. Subjects of the study were first grade children in the public school system of Warwick, R.I., whose speech handicaps were diagnosed as diffuse, nonorganic articulatory problems. Group members were screened and found to be free from physical anomalies of speech and otic mechanisms. Results of projective and nonprojective tests revealed more deviations in the developmental, psychosocial, and educational variables tested within the speech handicapped group than in the normally speaking group. The investigation suggests the existence of a relationship between diffuse, nonorganic articulatory disorders and psychosocial factors. Effective therapy for these children requires a complete and continuous study of the child, his total needs, his adaptive mechanisms, and his interpersonal relationships in addition to consideration of the articulatory problems. This article is based on a doctoral dissertation, Boston University.

SPEECH CORRECTION—ALASKA

178. Krantz, Henrietta C. *(Dept. of Health, Alaska Office Bldg., Juneau, Alaska)*

Volunteers assure success of speech and hearing program in Southeastern Alaska. *Hearing News.* Nov., 1958. 26:6:5-6, 18.

Describes the administration of a speech and hearing program for Southeastern Alaska begun in 1956 by the Alaska Department of Health. Originally set up as a demonstration project with the aid of the Alaska Crippled Children's Association, the program offers aid both to children and adults. Through the use of volunteers screening tests were given; the annual caseload has grown to 1,960 persons. These findings rule out the value of an essentially symptomatic treatment approach in speech therapy with children presenting diffuse nonorganic articulation problems and point to a need for additional research.

SPEECH CORRECTION—EQUIPMENT

179. Gibbons, Paul *(School of Dentistry, Univ. of Mich., Ann Arbor, Mich.)*

A supportive-type prosthetic speech aid, by Paul Gibbons and Harlan Bloomer. *J. Prosthetic Dentistry.* Mar., 1958. 8:2:362-369.

Describes the design and construction of a prosthesis for speech aid to a patient who had extensive pharyngeal and total palatal paralysis, the result of a 10-day illness from bulbospinal poliomyelitis. Following illness, the patient's speech intelligibility was poor with distortion of most of the consonant sounds. The appliance has been worn by the patient for more than two years; experience has shown that requirements of construction and wearability have been met. Instantaneous improvement was noted in his speech after the aid was placed in the patient's mouth. Consonant articulation was greatly improved and hypernasality considerably reduced. "Visible speech" patterns have shown that the patient's speech approximates that of a normal speaker when the appliance is *in situ.*

SWIMMING

180. Maurer, Adah

Teaching swimming to the slow learner; improvising new techniques when standard methods fail. *Chicago Schools J.* Nov., 1958. 40:2:81-87.

A physical education teacher discusses adaptations in the usual swimming instruction methods that were used in teaching slow learning children. The discussion has implications for other areas of instruction with children of this type.

TUBERCULOSIS

181. Carr, David T. *(200 First St., S.W., Rochester, Minn.)*

Vocational rehabilitation in pulmonary tuberculosis today, by David T. Carr and Ezra V. Bridge. *Am. Rev. Tuberculosis and Pulmonary Dis.* Oct., 1958. 78:4:647-649.

Editorial in reply, by Karl H. Pfuetze and Marjorie M. Pyle. p. 649-650.

Two editorials representing divergent points of view on the relative need for vocational rehabilitation in the total management of the patient with tuberculosis. Drs. Carr and Bridge state their belief that the need of the patient with tuberculosis for vocational rehabilitation should be evaluated objectively from the medical point of view. They offer data from an analysis of two series of patients from the Mayo Clinic and from Mineral Springs Sanatorium in Cannon Falls, Minn., to substantiate their belief. This type of public assistance, which is limited in availability, should be reserved for the physically disabled who have medical indications for vocational rehabilitation. The second editorial, by Drs. Pfuetze and Pyle, gives data from an analysis of records of patients admitted to Chicago State Tuberculosis Sanitarium. The economic and vocational status of these patients differed from those of the Minnesota samples; the majority needing vocational rehabilitation in the Chicago series were unskilled laborers in the age group under 60. These patients need counseling, help with job placement, and other services falling within the sphere of vocational rehabilitation.

William McCord Comments

Biology and Juvenile Delinquency

CRIME RATE VARIATIONS linked to age, sex, and race appear to be environmentally, rather than biologically, determined. . . . There is no direct evidence of a relationship between intelligence and crime nor between the functioning of the endocrine glands and crime. . . . Certain types of criminals—psychopathy, homosexuality, alcoholism, and psychotic criminality—may have a physiological or neurological background. . . . Assuming that there is such a thing as a "bad seed" (and there is little evidence for such an assumption), environment determines its growth.—*"The Biological Basis of Juvenile Delinquency," by William McCord, in* Juvenile Delinquency, *edited by Joseph S. Roucek. 1958. Philosophical Library, Inc., 15 E. 40th St., New York, N.Y. $10.00.*

Dr. Harry A. Pattison Comments

Rehabilitation Defined

THOSE WHO peruse this book will see that, throughout, in reference to the team, the key word is *cooperation;* and that, with reference to the patient, the key word is *individualization.* The reader will be convinced, I am sure, that the rehabilitation program is a scientific organization of convalescence to hasten recovery and guide the disabled to purposeful living. It helps to restore self-confidence and mental equilibrium; stabilize emotions; to find incentives to get well and to increase earning power. It lengthens life; enhances the joy of living; pays social dividends to families, industry and the State. It reduces sick benefits and unemployment payments."—*Harry A. Pattison, in Preface to* The Handicapped and Their Rehabilitation. 1957. *Charles C Thomas, 301 E. Lawrence Ave., Springfield, Ill. $14.75.*

New APA Division

THE NATIONAL COUNCIL on Psychological Aspects of Disability has been given divisional status in the American Psychological Association as Division 22. In a recent NCPAD election Lee Myerson, Ph.D., was voted president elect to succeed Frederick A. Whitehouse, Ph.D., the current president. William Gellman, Ph.D., was elected secretary, and Sidney Fishman, Ph.D., treasurer. The membership for 1958 was reported to be 204.

Residential Care for Cerebral Palsied

THE UNITED CEREBRAL PALSY Associations have asked their state and local legislative committees to work in 1959 toward state-supported special residential care for the cerebral palsied. As a result of a survey of state expenditures in 1957 for care of the cerebral palsied, it was learned that in most states no provision is made for their residential care. With few exceptions, the cerebral palsied are placed in institutions for the mentally retarded and mentally deficient.

New Appointment

DR. DONALD A. HARRINGTON, Associate Professor of Speech at the University of Florida, has been appointed to the newly created post of Specialist in Speech and Hearing in the Office of Education, U.S. Department of Health, Education, and Welfare. He will be a member of the Section on Exceptional Children and Youth, of which Dr. Romaine Mackie is Chief. Dr. Harrington has been director of training for speech and hearing therapists at the University.

Current Research

BULLETIN NO. 8, *Research Relating to Children,* prepared by the Clearinghouse for Research in Child Life, U.S. Children's Bureau, is now available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., for $1.00. It contains information on research reported March 1 to July 31, 1958. One section is devoted to research relating to exceptional children—the gifted, retarded, and physically handicapped.

Flower Therapy

TWICE EACH WEEK a three-tiered flower cart abloom with African violets brightens the halls of St. Luke's Hospital, St. Louis, Mo. Patients may choose any African violet they want, to watch, care for, and keep when they leave. A team of volunteers takes the flower cart around to various patients whose names have been supplied by the occupational therapist, the physical therapist, nurses on various divisions, and doctors who ask for the service. The Normandy African Violet Club supplies the plants and provides volunteers to operate the cart.

If You Become Disabled

THE BUREAU OF OLD AGE and Survivors Insurance, U.S. Social Security Administration, in November, 1958, published a booklet *If You Become Disabled* which explains some of the new provisions of the social security program. The booklet (*OASI-29*) is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at 10 cents a copy, $5.00 per 100.

Dental Care of Handicapped

DR. MANUEL M. ALBUM, research associate in oral pathology at the University of Pennsylvania and past president and charter member of the American Academy of Dentistry for the Handicapped, recently outlined a five-point philosophy for treating the handicapped child. He stated that—

Every child can be treated no matter what his physical or mental handicap.

Every child should receive the same dental care as you and I.

Every child deserves the utmost care that can be given him.

Every child should retain primary dentition as long as possible.

There is no child who cannot be treated dentally.—*From* Hawaii Health Messenger, *Department of Health, Territory of Hawaii, Honolulu, Hawaii, T.H., May-June, 1958, p. 1.*

New Publication

THE FIRST ISSUE of *Rehabilitacion,* official organ of the Bureau of Rehabilitation, Office of the Secretary of Health and Public Assistance, Mexico, D.F., Mexico, was published in November, 1958.

Dr. Frederick C. Bost Comments

Orthopedics and Rehabilitation Trends

REGARDING the socio-medical and the medical economic relationships of our specialty, Orthopaedic Surgery has had much experience. Our long association with the public care of the crippled child has brought us face to face with socialized medicine. Initiated for the care of the indigent crippled child, this program has been expanded to include virtually all of the crippled and disabled under the age of twenty-one years. . . ."

"In addition to the public, Federal and State programs, we have been confronted with many other programs of a quasi-public or private nature, societies such as the National Foundation for Infantile Paralysis, the United Cerebral Palsy Association, and the National Society for Crippled Children and Adults, to name but a few of the many. These programs are supported by private subscription and are therefore outside of our direct control."

"A joint committee on rehabilitation should be formed at once so that this time we will be prepared to meet our problem with a direct frontal attack rather than waiting until it is too late for anything other than a delaying action."—*"Quo Vadis Orthopaedia Americana," presidential address by Frederick C. Bost, in* J. Bone and Joint Surg., *June, 1958.*

Proceedings of International Conference

THE PUBLICATION *Conquering Physical Handicaps: The Proceedings of the First Pan Pacific Rehabilitation Conference* (held at Sydney, Australia, November, 1958, under the sponsorship of the International Society for the Welfare of Cripples and the Australian Advisory Council for the Physically Handicapped) may be ordered from the ISWC, 701 First Ave., New York 17, N. Y. The price is $1.50.

Research Position at NYU Established by Easter Seals

A THREE-YEAR GRANT of $51,150.00 has been made by the Easter Seal Research Foundation to New York University to establish a research position combining academic duties at the University with research at the Institute for the Crippled and Disabled.

Dr. Ruth Cooper Comments

Home Care Plans in the U.S. and Britain

THERE IS NO COUNTERPART in the United States for the British comprehensive provisions for care and rehabilitation of the chronically ill and aged, and for the variety of health services available in the home. In this country, home-care plans, which extend the hospital team into the community—housekeeping services, and rehabilitation centers are increasing in numbers, but these are seriously handicapped in meeting needs because of inadequate financing and availability only in more metropolitan areas. Perhaps the best and most available local home health service in the United States is the public health nurse."—*"Trends in Medical Social Work in the United Kingdom and the United States," by Ruth Cooper, in* Social Service Review, *December, 1958, p. 388.*

Clothing for the Disabled

THE NEW YORK UNIVERSITY-Bellevue Medical Center has received a grant of $11,040 from the Office of Vocational Rehabilitation to be used in designing, testing, and developing special clothing for the physically handicapped. The grant was made in the name of Dr. Howard A. Rusk, chairman of the Department of Physical Medicine and Rehabilitation at the Center.

THE DECEMBER 1958 ISSUE OF *Modern Medicine* carried an article on fashions for the handicapped, with photo illustrations. Garments are attractive and are designed for handicapped men and women with their special needs in mind. The label carried is Functional Fashions designed by Helen Cookman. Sears, Roebuck & Co. are listing the fashions in their catalog, referring those interested to the distributor, Clothing Research, Inc., 307 W. 38th St., New York 18, N. Y., a nonprofit organization.

"Disability" and "Handicap"

IN THE MAY-JUNE, 1958, issue of the *Journal of Mental and Physical Rehabilitation,* Sidney Z. Brent discussed how, in the comparatively new field of rehabilitation, some words rapidly become changed in connotation or obsolete while others are newly introduced or are made more definitive. Although some people still use "disability" and "handicap" interchangeably, they are coming to have descriptive and distinctly different meanings. Disability, which may be temporary or permanent, is equivalent to the physician's diagnosis. Handicap is the evaluation or consequence of the disability in terms of inability to perform, which also may be temporary or permanent. Thus, a permanent disability does not necessarily mean a permanent handicap. A man who loses a leg has a permanent disability, but, when he is fitted with an artificial leg that enables him to walk, almost all the resulting handicaps are eliminated. An example of a permanent disability with a permanent handicap is permanent paralysis from the waist down resulting from a spinal cord injury causing the permanent handicap of inability to walk.

Disability and handicap are gradually replacing the terms crippled, invalid, and impaired. Before 1940, these latter terms were used to describe disabled persons and, connoting total inability, virtually relegated disabled persons to a life of unproductivity, regardless of ability. Mr. Brent stated, "There are some rehabilitation agencies, nevertheless, which still bear the undesirable terms of 'crippled' and 'impaired' in their organizational names, indicating either a reluctance to accept, or a lack of understanding of, the more distinctive usage of the words 'disability' and 'handicap.' "

South Africa

THERE ARE AT PRESENT 14 Sheltered Employment factories and two farms in the Union, providing employment for approximately 1,800 handicapped individuals."—*"Sheltered Employment,"* Rehabilitation in S.A., *September, 1958,* p. 109.

Epileptics Can Hold Jobs!

IN NEW YORK STATE every year since 1945, the average number of compensated cases caused by accidents due to epileptic seizures has been only 9 of a total of 100,000 annual cases. In 1957, the first year of operation of Epi-Hab L.A., Inc., a nonprofit industrial workship for epileptics rejected by industry, there were only 3 accidents reportable under workmen's compensation. Of 51 Epi-Hab employees, 23 had seizures in the shop, with an average loss of time of 32 minutes. Ten per cent of the group had 70% of the seizures. Among 20 epileptics who are not self-supporting, only 1 cannot work because of illness, 1 does not want to work, 2 are not reliable, and 16 are employable." —*From* Patterns of Disease, *December, 1958, Parke, Davis & Co., Detroit 32, Mich.*

What Every Blind Person Should Know

THE AMERICAN FOUNDATION FOR THE BLIND has recently published a series of folders that includes *Diabetes and Blindness, Life Insurance for the Blind* (revised edition), *Financial Aid to Blind Persons, Election Laws Affecting Blind Persons,* and *Income Tax Exemption for Blind Persons.* The address of the Foundation is 15 W. 16th St., New York 11, N. Y.

Special Education Guides for North Dakota

THE DIVISION OF SPECIAL EDUCATION of the State Department of Public Instruction, Bismarck, N. D., has issued a series of mimeographed guides to special education for school administrators of the state. Miss Janet M. Smaltz is director of the Division. Included in the series are parts: I. *Review of Special Education Programs* (36 p.); II. *Classes for Educable Mentally Handicapped Childern* (83 p.); III. *Speech Therapy in the Public Schools* (96 p.); V. *Visiting Counselors to School Children Who Are Socially and Emotionally Maladjusted* (32 p.); VII. *Instruction Programs for Children Who Are Homebound or Hospitalized* (11 p.); VIII. *Setting Up Summer Speech Clinics* (11 p.); and IX. *The Gifted Child* (25 p.). Forms and bibliographies are included in the guides.

SSA Disability Payments

OF THE 1,081,600 APPLICATIONS for disability payments received in the three and one-half years of the liberalized disability program, 572,800 (about 53%) have been approved by the Social Security Administration, according to Dr. William Roemmich, chief medical officer of the Division of Disability Operations, Bureau of Old Age and Survivors Insurance. The figures pertain only to those completing a medical evaluation after applying.

Alton F. Lund Comments

Parents Who Help Other Children Help Their Own

THE IDEAL LESSON for the parent to learn is: He helps his own child most by working for all children. This does not lessen interest in his own child, but his perspective changes. He sees that a truly worthwhile program which will build a community in which his child may function to the best advantage, can only be accomplished when that program encompasses all children. Although his child may not be particularly benefited by a particular program, other children will benefit and thereby build up a program in which his child can eventually participate. He must sometimes wait his turn."—*"The Role of Parents in Helping Each Other," by Alton F. Lund, in* Counseling Parents of Children with Mental Handicaps; Proceedings of the 33rd Spring Conference. *The Woods Schools for Exceptional Children, Langhorne, Pa. 1958.*

Conference on Blind

A CONFERENCE ON GUIDANCE PROGRAMS with Blind Pupils will be held April 9-11 under the cosponsorship of the Perkins School for the Blind and the American Association of Instructors of the Blind. Information may be obtained by writing to: Carl J. Davis, Head, Department of Psychology and Guidance, Perkins School for the Blind, Watertown 72, Mass.

Aim of Recreation

THE PRINCIPAL AIM of recreation programs for homebound children should be, broadly, to assure to the extent possible the maintenance and support of their normal psychological and social development and ability to develop relationships outside of the family."— *Mrs. Katherine B. Oettinger.*

There is a distinct philosophy underlying the form of recreation for the handicapped. First, they are in a social group working together to attain certain skills; and, second, in this new element they find an activity in which they participate. Some of these people have been handicapped from birth, others as a result of accident or disease. They have all grown accustomed to being helped too much and they need to learn more self-reliance. We are in the recreation field and are trying to provide new interests, social contacts, development in personality, a change of outlook, and enrichment of life."— *Mrs. Judy Shor. From* Proceedings of the Third Hospital Recreation Institute: Recreation for the Ill and Handicapped Homebound. *1958. Mimeo. National Recreation Association, 8 W. Eighth St., New York 11, N.Y. $1.25.*

Wheel Chair Homes for Veterans

AS OF SEPT. 30, 1958, federal grants totaling more than $51 million had been made to over 5,400 of 7,091 veterans establishing eligibility for special grants because of a need for special type home. The Veterans Administration, under grants first authorized in 1948, defrays 50% of the cost of "wheel chair homes" for eligible veterans, up to a maximum of $10,000.

A. L. Ruess Comments

The Team Psychologist and the Patient with Cleft Palate

OF ALL THE DIMENSIONS of personality necessary for satisfactory and successful social interaction, facial configuration and oral communication are probably two of the most important. 'Abnormality' of either may lead to social and personal maladjustment. . . . The long-term needs of many cleft palate patients require relatively large expenditures of money, time and effort which could undoubtedly be reduced to a minimum through better understanding of the psychological factors working to impair or enhance the habilitation. . . .

"It is not surprising . . . that the clinical psychologist has been a latecomer. With the advent of the cleft palate team only *yesterday* it was imperative that the basic disciplines on the team—pediatrics, surgery, dentistry and speech therapy—be given the time to consolidate their understanding and their knowledge of the problem, the basic techniques involved and the inter-relationship of the various therapies before new members could be included. This period of growth made it possible to develop a degree of sophistication and insight through which the social and psychological problems of the cleft palate patient came more clearly into focus. At this point the clinical psychologist came onto the scene as a team member. . . .

"Not only does the team psychologist gain greater insight and understanding of the psycho-dynamics of the cleft palate individual through team interaction, but conversely, the psychologist through his contributions enhances his co-workers' understanding of the 'whole' patient. The efficiency of the team undoubtedly revolves around the nature of this interaction. In fact, a postulate concerning the group dynamics of the habilitation team might be stated to the effect that the efficiency of the team, within the limits imposed by individual competency and knowledge of the phenomena, is directly proportional to each member's understanding and tolerance of the other team disciplines."— *"The Clinical Psychologist in the Habilitation of the Cleft Palate Patient," by A. L. Ruess, in* J. Speech and Hear. Disorders, *November, 1958, p. 561.*

Rehabilitation Just Beginning

WE ARE JUST at the beginnings of a science of rehabilitation. The day must soon come when no alert community can neglect this important area, when no medical center is considered to be really a center unless it has an adequate rehabilitation program, and when this program reaches into every home, rich and poor alike. It will then be accepted that in treatment we do not stop by merely making people well, but well and useful."—*"Rehabilitation of the Cardiac Patient," by Louis N. Katz, in* Circulation, *January, 1958.*

Bibliography Available

MR. EDWARD GOLDSTEIN, a high school teacher of occupational studies, has prepared a nine-page mimeographed source and reference list of materials, including films, for teaching secondary mentally handicapped classes, available for $1.00. Requests should be addressed to Mr. Goldstein at 86-15 208th St., Queens Village, 27, New York.

Cancelled Auto Insurance

THE INDOOR SPORTS CLUB through their publication *National Hookup* is assisting Mrs. Margaret Barrett, 2017 66th Ave., Philadelphia 38, Pa., conduct a survey of handicapped persons experiencing discrimination in coverage by auto insurance companies.

Rehabilitation Centers Defined

THE FOLLOWING is a tentative system of definitions for rehabilitation centers.

"A *rehabilitation center* is an establishment with permanent facilities and two or more of the following services directed wholly or chiefly to patients or disabled persons in a program of rehabilitation: medical services, psycho-social services, and vocational training or educational services.

"A *patient rehabilitation center* is a rehabilitation center with its medical (physician and paraphysician) and psycho-social services directed wholly or chiefly to patients in a program of rehabilitation.

"A *trainee rehabilitation center* is a rehabilitation center with its psycho-social and vocational or educational training services directed wholly or chiefly to disabled persons in a program of rehabilitation.

"A *comprehensive rehabilitation center* is a combination of a patient rehabilitation center and a trainee rehabilitation center.

"An *inpatient rehabilitation center* is a patient rehabilitation center with its services directed wholly or chiefly to inpatients in a program of rehabilitation.

"An *outpatient rehabilitation center* is a patient rehabilitation center with its services directed wholly or chiefly to patients who receive no lodging in a program of rehabilitation."—*"Ordered Definitions: Patient Center, Paraphysician, Parahospital . . ." by Don Chill and Alan E. Treloar, Ph.D., in* Hospitals, *November 1, 1958.*

New Pennsylvania Center

THE NEW 350-BED Rehabilitation Center at Johnstown, Pa. is scheduled to open the first of March, 1959. Operated by the State Bureau of Vocational Rehabilitation, the Center will train severely handicapped persons from all parts of the state who are referred to the Center by the Bureau.

Changes of Address

AMERICAN HEARING SOCIETY, national offices. To: 919 18th St., N.W., Washington 6, D.C.

AMERICAN HOSPITAL ASSOCIATION, headquarters. To: 840 N. Lake Shore Dr., Chicago 11, Ill.

AMERICAN NURSES' ASSOCIATION, headquarters. To: 10 Columbus Circle, New York 19, N.Y. *Also* National League for Nursing; American Journal of Nursing Company; ANA Professional Counseling and Placement Service.

GOODWILL INDUSTRIES OF AMERICA, INC. To: 1913 N St., N.W., Washington, D.C.

INTERNATIONAL ASSOCIATION OF LARYNGECTOMEES. To: National office of the American Cancer Society, 521 W. 57th St., New York 19, N.Y. Jack Ranney, executive secretary of the Association, is editor of the *IAL News.*

SOUTHERN REGIONAL EDUCATION BOARD. To: 130 Sixth St., N.W., Atlanta, Ga. William C. Geer, head of the SREB program in education of exceptional children since 1956, is now regional programs associate.

Author Index

National and International Meetings

1959

March

American Association for Health, Physical Education, and Recreation. National convention, March 29-April 3. Municipal Auditorium, Portland, Ore. Mr. Carl A. Troester, Jr., Exec. Secretary, 1201 16th St., N.W., Washington 6, D.C.

American Orthopsychiatric Association, March 30-April 1. Sheraton Palace Hotel, San Francisco. Dr. Marion F. Langer, Exec. Secretary, 1790 Broadway, New York 19, N.Y.

American Personnel and Guidance Association. Annual convention, March 23-26. Hotel Cleveland, Cleveland. For information on registration, write: Mr. John Rowland, Rocky River Public Schools, 2985 Wooster Rd., Cleveland, Ohio.

National Association of Recreational Therapists. 1959 Conference, March 9-12. Hotel Willard, Washington, D.C. Anne K. Bushart, Arrangements Chairman, St. Elizabeth's Hospital, Nichols Ave., S.E., Washington 20, D.C.

National Health Council, March 17-19. Palmer House, Chicago. Mr. Philip E. Ryan, Exec. Director, 1790 Broadway, New York 19, N.Y.

National Multiple Sclerosis Society, March 9. New York. Mr. Donald Vail, Secretary, 257 Fourth Ave., New York 10, N.Y.

April

American Academy of General Practice. April 6-9. San Francisco. Mr. Mac F. Cahal, Exec. Secretary, Volker Blvd. at Brookside, Kansas City 12, Mo.

American Academy of Neurology, April 13-18. Statler Hotel, Los Angeles. Dr. Joseph M. Foley, Secretary, Boston City Hospital, Boston, Mass.

American Academy of Pediatrics. Spring session, April 13-15. Sheraton Palace, San Francisco. Dr. E. H. Christopherson, Exec. Secretary, 1801 Hinman Ave., Evanston, Ill.

American Association for Cleft Palate Rehabilitation, April 30-May 2. Sheraton Hotel, Philadelphia. Dr. D. C. Spriestersbach, Secretary, University Hospitals, Iowa City, Iowa.

Council for Exceptional Children, April 7-11. Hotel Ambassador, Atlantic City. Mr. Harley Z. Wooden, Exec. Secretary, 1201 16th St., N.W., Washington 6, D.C.

Family Service Association of America. Biennial meeting, April 1-3. Sheraton-Park Hotel, Washington, D.C. For information, write: Family Service Assn. of America, 215 Fourth Ave., New York 3, N.Y.

May

American Association on Mental Deficiency, May 19-23. Hotel Schroeder, Milwaukee. Dr. Neil A. Dayton, Secretary-Treasurer, Mansfield State Training School, Mansfield Depot, Conn.

American Pediatric Society, May 6-8. The Inn. Buck Hill Falls, Pa. Dr. A. C. McGuinness, Secretary, 2800 Quebec St., N.W. Washington 8, D.C.

Inter-American Conference on Rehabilitation (Fourth), May 20-23. San Juan, Puerto Rico. Sponsored by the International Society for the Welfare of Cripples. Inquiries and registration should be sent to Dr. Herman Flax, Professional Building, Suite 301, Santurce 34, Puerto Rico.

National Conference on Social Welfare. 86th Annual Forum, May 24-29. San Francisco. Headquarters hotels: Sir Francis Drake, Whitcomb, and Sheraton-Palace. Mr. Ralph Price, Asst. Exec. Secretary and Annual Forum Manager, 22 W. Gay St., Columbus 15, Ohio.

National League for Nursing. Biennial convention, May 11-15. Philadelphia. Miss Anna Fillmore, Secretary, 10 Columbus Circle, New York 19, N. Y.

National Tuberculosis Association, May 24-29. Palmer House, Chicago. Mrs. Wallace B. White, Secretary, 1790 Broadway, New York 19, N.Y.

Society for Pediatric Research, May 8-9. The Inn, Buck Hill Falls, Pa. Dr. Clark D. West, Secretary, Children's Hospital, Cincinnati 29, Ohio.

June

American Diabetes Association, June 6-7. Chalfonte-Haddon Hall, Atlantic City. Dr. Paul Sheridan, Secretary, 1 E. 45th St., New York 17, N.Y.

American Geriatric Society, June 4-5. Hotel Traymore, Atlantic City. Dr. Richard J. Kraemer, Secretary, 2907 Post Road, Warwick, R. I.

American Hearing Society. 40th Annual Convention, June 9-12. Fountainbleau Hotel, Miami Beach. Mr. Crayton Walker, Exec. Director, 919 18th St., N.W., Washington, D.C.

American Instructors of the Deaf. Annual convention, June 28-July 3. Colorado Springs, Colo. Sister Rose Gertrude, Secretary, St. Mary's School, 2253 Main St., Buffalo, N.Y.

American Medical Association, June 8-12. Hotel Traymore, Atlantic City. Dr. F. J. L. Blasingame, Secretary, 535 N. Dearborn St., Chicago 10, Ill.

American Medical Women's Association, June 4-7. Sheraton Ritz Carlton Hotel, Atlantic City. Miss Lillian T. Majally, Exec. Secretary, 1790 Broadway, New York 19, N.Y.

American Neurological Association, June 15-17. Claridge Hotel, Atlantic City. Dr. Charles Rupp, Secretary, 133 S. 36th St., Philadelphia 4, Pa.

American Orthopedic Association, June 16-18. Lake Placid Club, Lake Placid, N.Y. Dr. Lee Ramsey Straub, Secretary, 715 Lake St., Oak Park, Ill.

American Physical Therapy Association. 36th Annual Convention, June 21-26. Hotel Leamington, Minneapolis. Miss Jean C. Bailey, Secretary, 157 N. 79th St., Milwaukee 13, Wis.

American Rheumatism Association, June 2-6. Mayflower Hotel, Washington, D.C. Dr. Edward F. Hartung, Secretary, 580 Park Ave., New York 21, N.Y.

Medical Library Association, June 15-19. King Edward-Sheraton Hotel, Toronto, Canada. Miss Nettie Mehne, Secretary, The Upjohn Co., Kalamazoo, Mich.

Mediterranean Conference on Rehabilitation (First), June 9-13. Athens, Greece. Sponsored by the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y.

National Education Association. Annual convention, June 28-July 3. St. Louis. Mr. William G. Carr, Exec. Secretary, 1201 16th St., N.W., Washington 6, D.C.

July

International Congress of Paediatrics, July 19-25. Montreal, Canada. Dr. R. L. Denton, 2300 Tupper St., Montreal 25, Que., Canada.

World Council for the Welfare of the Blind. General Assembly, July 22-31. Rome, Italy.

August

American Congress of Physical Medicine and Rehabilitation. 37th Annual Session, August 30-September 4. Hotel Leamington, Minneapolis. Dorothea C. Augustin, Exec. Secretary, 30 N. Michigan Ave., Chicago 2, Ill.

American Hospital Association. Annual Convention, August 24-27. Coliseum, New York City. Convention headquarters, Statler Hotel. Dr. Edwin L. Crosby, Secretary, 18 E. Division St., Chicago, Ill.

International Congress for Speech and Voice Therapy, August 17-22. London, England. Miss M. Carter, Secretary, 46 Canonbury Sq., London, N. 1, England.

World Federation for Mental Health, August 30-September 5. Barcelona, Spain. Miss Esther M. Thornton, Secretary-General, 19 Manchester St., London, W. 1, England.

September

American Psychological Association, September 3-9. Cincinnati. For information, write to: Roderick H. Bare, c/o American Psychological Assn., 1333 16th St., N.W., Washington 6, D.C.

World Congress for Physical Therapy, September 6-12. Paris, France. Miss M. J. Neilson, Tavistock House, Tavistock Sq., London, W. C. 1, England.

World Medical Association, September 7-12. Montreal, Canada. Dr. Louis H. Bauer, Secretary-General, 10 Columbus Circle, New York 19, N.Y.